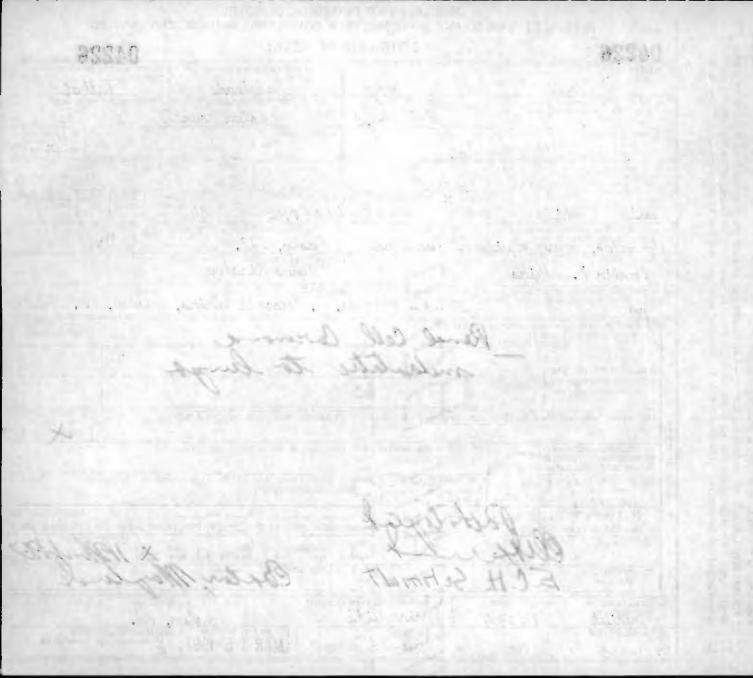
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 04226  | CERTIFICATE   | OF DEATH   | 049  | 226                           |
|--|---|--|--|-------------------------------|
| 1. PLACE OF OEATH  |   | 2. USUAL RESIDENCE (Where dec  |  | nce before admission)         |
| o. COUNTY Talkat   | MARYLAND  | o. STATE Marulani  | b. COUNTY  | albot                         |
| b. CITY OR TOWN (If outside corporate limit  | ts, c. LENGTH OF STAY IN 16   | c. CITY OR TOWN (If outside corp   |  |                               |
| write RURAL only give neorest town)  | 24 days.  | Easton   | (rural)  | 20-1                          |
| d. NAME OF HOSPITAL OR INSTITUTION (If n   | not in hospital, give street address)   | d. STREET ADDRESS  |  | e. IS RESIDENCE<br>ON A FARM? |
| Memorial +   | tospital  |  |  | YES 🔼 NO 🗌                    |
|  | irst Middle   | Lost 4. DAT  | E Month  | Doy Year                      |
| OFCEASED (Type or print) Charles   | hussell H   | OCLOS DEA  |  | 11 1967                       |
| S. SEX 6. COLOR OR RACE  | THE REAL PROPERTY OF THE PERTY | B. DATE OF BIRTH   | 9. AGE (in years IF UNDER  Jost birthdoy) Months | Days Hours Min.               |
| male white   | WIDOWED DIVORCED  | 4/30/1902  | 64 yrs.  |                               |
| IOo. USUAL OCCUPATION (Give kind of work done<br>during most of working life, eyen if retired)       | IMPLICTOV   | 11. BIRTHPLACE (County & Stote, o  | r foreign country) 12. (                         | OUNTRY?                       |
| Uperator, heavy eg   |   | Casey, Ill.  | <u> </u>   | 1371                          |
| 13. FATHER'S NAME Martin L. Adkins   |   | 14. MOTHER'S MAIDEN NAME<br>Donna Kinsl  | OID .  |                               |
|  |   | NFORMANT   | Address  |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES! (Yes, no, or unknown) (If yes give wor or dotes          | of service) 16. SOCIAL SECURITY NO. 17. II  | o. C. Russell A  |  | ML RFD                        |
| no   |   | o. C. Muss coc r.  | coording Coording                                | I INTERVAL BETWEEN            |
| 18. CAUSE OF DEATH (Enter only one co<br>PART I. DEATH WAS CAUSED BY:                                | buse per the for (0), (b), and (c).   | No remained  |  | ONSET AND DEATH               |
| IMMEDIATE CAUSI  |   | Control  |  |                               |
| Conditions, if ony, which gove   | my tastati  | to le  | ~ns  |                               |
| rise to immediate cause (a),   | (b) <b>M</b> (b) <b>E</b> TO  |  | 17:  |                               |
| stoting the underlying cause   | (c)   |  |  |                               |
| PART II OTHER SIGNIFICANT CONDITIONS   | CONTRIBUTING TO DEATH BUT NOT RELATED TO  | THE TERMINAL DISEASE CONDITION O   | GIVEN IN PART 1(o)                               | 19. WAS AUTOPSY               |
|  |   |  |  | PERFORMEO?<br>YES NO          |
| 200, ACCIDENT WAS UNDERLYING  200 OR CONTRIBUTING CAUSE OF OEATH (IE FITHER NOTIFY MEDICAL EXAMINER) | 205. DESCRIBE HOW INJURY OCCURRED.  | (Enter nature of injury in Part I or   | Port II of item 18.)                             |                               |
| OR CONTRIBUTING CAUSE OF CEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                  |   |  |  |                               |
| 20c. TIME OF INJURY Month, Doy, Yeor   |   | CE OF INJURY (Home, form, 20   | f. (City or town) (C                             | ounty) (Stote)                |
| Hour o.m.  |   | tory, street, office bldg., etc.)  |  |                               |
| 21. I certify that (I) (this ha  | softal attended the deceased from   | , 19   | , ta, 19   | , that (I) (we) las           |
| saw the deceased alive an  | TOUT WING the   | t death accurred at 9 49   | M, fram causes and an                            | the date stated above         |
| 220. SIGNATURE   |   | ATTENDING MED.   | STAFE 22b  | DATE SIGNED / DE              |
| een  | Territ M.   | D. PHYS. DIRECTO   |  | Marin 101                     |
| 22c. PHYSICIAN'S<br>NAME (Type)  | H Gatimidt  | 22d. ADDROS  | in Mond  | end                           |
| p-t.   | - 11 10 111 1111  |  | 1 111  |                               |
| 23o. BURIAL, CREMATION, 23b. DATE TO REMOVAL (Specify)   |   | CREMATORY 23d.   | LOCATION (City or Town)                          | (County) (Stote)              |
| REMOVAL (Specify) 3/13/  | 1967 Spring Hill  | as a precio py pro   | Caston, Ad.                                      | -CICNATHPE                    |
| 24. EUNERAL DIRECTOR   | ADORESS   | AAR 1 5  | 1967 Sb. BEGISTRAR'S                             | es judge                      |
| mulle andlew   | MALDIN MICHANI  | ONECE ON THE PERSON OF THE PER | 1001   | 11 0                          |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remays sepan papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar remayal, and in any eyent, within 72 hours after death.

VR A15 (4) 20 M 1/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after depressed may be retained by the haspital at attending physician.



fureral and 2 death. death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please-remove carbon papers. Pages 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after

|                                | MARYLAND STATE DEF    | ARTMENT OF     | HEALTH               |          |
|--------------------------------|-----------------------|----------------|----------------------|----------|
| <b>DIVISION OF STATISTICAL</b> | RESEARCH AND RECORDS, | 301 W. PRESTON | STREET, BALTIMORE 1, | MARYLAND |
| <br>00**                       | CEDTIFICATE           | OF DEATH       | 0.400                | N PM     |

| 04221   | CERTIFICATE                     | UF DEATH                       | 0422                                 |                                |
|---|---------------------------------|--------------------------------|--------------------------------------|--------------------------------|
| 1. PLACE OF DEATH   |                                 |                                | there deceased lived, if institution |                                |
| a. COUNTY<br>TALBOT   | MARYLAND                        | MARYLAND                       | b. COUNTY<br>TALB                    | OT                             |
| <ul> <li>CITY OR TOWN (if outside corporate limits,<br/>write RURAL and give nearest town)</li> </ul>   | c. LENGTH OF STAY IN 1D         |                                | de corporate limits, write RUF       |                                |
| EASTON  | 3 months                        | Easton                         |                                      | 20-1                           |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in   |                                 | d. STREET ADDRESS 16           | Goldsboro St.                        | e. IS RESIDENCE<br>ON A FARM?  |
| HOUSE IN THE PINES *  | EASTON                          | REXXXXXXXX                     | 95                                   | YES NO 3                       |
| . NAME DF FIrst   | Middle                          | Last 4.                        | DATE Month                           | Day Year                       |
| (Type or print) CHARLES   | BENJAMIN 3                      | REININGER                      | DEATH 3-29-6                         | 7 19                           |
| 6. COLOR OR RACE   7. MARRIE  | D NEVER MARRIED 8               | . DATE OF BIRTH                | 9. AGE (In years IF UNI              | DER 1 YEAR IFUNDER 24 HRS.     |
| M MIDOME  |                                 | -13-1881                       | yrs. Month                           | is Days Hours Min.             |
| Oa. USUAL OCCUPATION (Give kind of work done   10b. uring most of working life, even if retired)  | KIND OF BUSINESS OR<br>INDUSTRY | 11. BIRTHPLACE (County         | 8                                    | CITIZEN OF WHAT                |
| Veterinarian  | ALL COMP                        | Berks Pa                       | ů.                                   | 11.54                          |
| 3. FATHER'S NAME  |                                 | 14. MOTHER'S MAIDEN N          | 1.4                                  |                                |
| Joel Breininger   |                                 | Susannah I                     | Kutz                                 |                                |
| 15. WAS DECEASED EVER INU.S. ARMED FORCES?   1  | 6. SOCIAL SECURITYNO.   17.     | INFORMANT                      | Address                              |                                |
| (Yes, no, or unkown) (If yes give war or dates of service)  | 215-44-6180 Mrs                 | . Belle Andr                   | cws. Hurlock.                        | Md.                            |
| 1 18. CAUSE OF DEATH [Enter only one cause per  |                                 |                                |                                      | INTERVAL RETWEEN               |
| PART I. DEATH WAS CAUSED BY:  |                                 | Reart Day                      | Quino:                               | ONSET AND DEATH                |
| H 200   | - Legenton-o                    |                                |                                      |                                |
| Conditions, If any, which   | torias Coro                     | tic and re                     | leumatic                             | Unknoun                        |
| gave rise to immediate  |                                 | 0                              |                                      | 1                              |
| underlying source lock  |                                 | Keant du                       | sease                                |                                |
|   | BUTING TO DEATH BUT NOT RELA    | TED TO THE TERMINAL DISEA      | SECONDITION GIVEN IN PART 1          | (a) 19. WAS AUTOPSY PERFORMED? |
| 3   |                                 |                                |                                      | YES NO                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRI  20a. ACCIDENT WAS UNDERLYING   20b. OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | DESCRIBE HOW INJURY OCCU        | RRED. (Enter nature of inju    | ry in Part I or Part II of Item      | 18.)                           |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 |                                |                                      |                                |
|   | INJURY OCCURRED   20e, PLAC     | E OF INJURY (Home, farm,       | 20f. (City or town) (                | (County) (State)               |
| 20c. TIME OF INJURY Month, Day, Year 20d.<br>Hour a.m. Whi<br>p.m. 19 at w  | IO MOT WHITE M                  | y, street, office bldg., etc.) |                                      |                                |
| 21. I certify that (I) (this hospital) atter  |                                 | . 19                           | . to 19                              | that (i) (we) last             |
| saw the deceased alive on   | 19 and that                     |                                | _M, from the causes and o            |                                |
| 22a. SIGNATURE  | and that                        | acath occurred off             |                                      | DATE SIGNED                    |
| Pagent W.   | Trever M.D.                     | ATTENDING MED.                 | CTOR PHYS.                           |                                |
| 22c. PHYSICIAN'S  |                                 | 1 22d. ADDRESS                 | 4                                    |                                |
| NAME (Type) Robert W. In  | evon                            | Caston,                        | rice.                                |                                |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF   | 23c. NAME OF CEMETERY           | OR CREMATORY   2               | 3d. LOCATION (City, town or          | county) (State)                |
| Removal Burial 4/1/1967   | Fairview Cen                    | reteru.                        | Kutztown, Pa.                        |                                |
| 24. FUNERAL DIRECTOR  | ADDRESS                         |                                | Y REGISTRAR   256. REGISTR           | RAR'S SIGNATURE                |
| Marice & Menoram  | 2 Den Erster                    | The MAR 3                      | 1 1967 / Clear                       | las Juige                      |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after deathn TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14228
CERTIFICATE OF DEATH

| 01000   | 0.000  |
|---|--|
| 1. PLACE OF DEATH TO PLAT   | a. STATE Manufand b. COUNTY Talbot   |
| b. CITY OR TDWN (I outside corporate limits, write RURAL and give nearest town)  C. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                                     |
| Eastow 1  | Easton 20-1  |
| NAME OF HDSPITAL DR INSTITUTION of not in hospital, give street address)  | d. street address  Route 50    B. Is residence on a farm?  |
|   | 7.00   |
| 3. NAME DF BEGEASED (Type or print) Pulp First Leury (  | Correll 4. DATE OF Month Day Year 7  |
| A MARKIED X HEVER MARKIED   | 8. DATE OF BIRTH 9. AGE (In years   IFUNDER 1 YEAR   IFUNDER 24 HRS.   last birthday)   Months   Days   Hours   Min. |
| male white WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OF A 1  | 4/1/2// 1925 4/ yrs.   A-11. BIRTHPLACE (County & State, or fereign country)   12. CITIZEN OF WHAT                   |
| Ounce operator Package Stones Gas   | Talbot Maryland 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |
| Willard F. Carroll  | Estella Stradley   |
| 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SOCIAL SECURITY ND. 17. (Yes, no, or unknown) ((If yes give war or dates of service)  | INFDRMANT Address  |
| Yes WW 11 218-16-7472 Mrs   | s. Philip H. Carroll, Easton, Md.  |
| 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]   | INTERVAL BETWEEN   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Quite my   | ocardial infarction 3-20-67  |
| 4201 DUE TO 0 +   | 0 +: 0 +1:10 2   |
| conditions, If any, which gave rise to immediate (b)  | terous reare asserse of  |
| cause (a), stating the DUE TD underlying cause last. (c)  | Ert  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA  208. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCU DR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | PERFORMED?   |
| OD ACCIDENT WAS UNDERSTOOD TO 1 OOK DESCRIPTION INVITED ON  | YES ND   |
|   | JRREO. (Enter nature of injury in Part 1 or Part 11 of Item 18.)   |
|   | CE OF INJURY (Home, farm, 2Df. (City or town) (County) (State)   |
| Hour a.m.  p.m.  19   While   Not While   factor   factor   while   factor   factor | ny, an eet, emee orag., etc./  |
| 21 Leartify that //\ /this hamitally attended the deserred from   |  |
| saw the deceased alive on 3/23 1967 and that  | t death occurred at M, from the causes and on the date stated above.   |
| 22a. SIGNATURE  | ZZD DITE GIGHED  |
| Robert W. Trever M.D  | D. ATTENDING MED. STAFF DIRECTOR PHYS.   |
| 22c. PHYSICIAN'S<br>NAME (Type)   | 22d. ADDRESS   |
| 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY 3/25/1967 Woodlawn Mem   |  |
| 24. FUNERAL DIRECTOR ADDRESS  | 1252, BEC'D BY REGISTRAR! 25b. BEGISTRAR'S SIGNATURE   |
| Maurin & newram + Son Eastor  | DATE DATE 1961 guaries Judges  |

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 04229   | CEKTIFICATE                             | OF DEATH   | 0422  | 3                                       |
|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY  1. PLACE OF DEATH  | MARYLAND                                | 2. USUAL RESIDENCE (Where decease o. STATE Maryland            | a I continue am                                     | nce before admission)  Lbot             |
| b. CITY OR TOWN (If outside corporate limits, write RUBAL-and give neorest town)  | c. LENGTH OF STAY IN 16  Gays           | c. CITY OR TOWN (If outside corpara  Trappe  d. STREET ADDRESS | te limits, write RURAL and give (nunal)             | 20-1                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospit  | ospital                                 | RFD  |   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF DECEASED (Type or print)   | m Danie                                 | Arroll 4. DATE OF DEATH  |   | Day Year 19 6 7                         |
| 110000  | DIVORCED D                              | 4/20/1883  | AGE (In years  By birthday)  Yrs.  IF UNDER  Months | Days Hours Min.                         |
| during-most of working life, even if retired) Farming   | b. KIND OF BUSINESS OR<br>INDUSTRY      | 11. BIRTHPLACE (County & Stote, or to Talbot Maryla            |   | OUN RT 2                                |
| 13. FATHER'S NAME<br>Jeremiah Carroll   |   | 14. MOTHER'S MAIDEN NAME<br>Annie Trice                        |   |   |
| IS. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, na, ar unknown) (If yes give war ar dates of service)  | 14. 502                                 | INFORMANT  S. William M. Ca                                    | erroll, Trapp                                       |   |
| 18. CAUSE OF DEATH (Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Canditions, if any, which gave rise to immediate cause (a). | tente myora                             | ritial infar   | tion  | INTERVAL BETWEEN ONSET AND DEATH        |
| stating the underlying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION  | HE TO STATU BUT HOT BELLTED TO          | THE TERMINAL DISCASS CONDITION CIVE                            | EN IN DART Vol                                      | 10 WAS AUTOPSY                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES NO       |
| OR CONTRIBUTING CAUSE OF DEATH  | DESCRIBE HOW INJURY OCCURRED.           | (Enter nature of injury in Part I ar Por                       | t II of item 18.)                                   |   |
| Haur a.m.   |   | CE OF INJURY (Hame, form, tory, street, affice bldg., etc.)    | (City or town) (Co                                  | ounty) (State)                          |
| 21. I certify that (I) (this haspital) at saw the deceased alive an   | tended the deceased fram<br>19, and tha | , 19, t<br>t death accurred at // 🥞 N                          | M, fram causes and an                               |   |
| 22a. SIGNATURE  ReGert W.  22c. PHYSICIAN'S NAME (Type)   | Trever M.                               | D. ATTENDING MED. PHYS. DIRECTOR 22d. ADDRESS                  | STAFF 22b.  | DATE SIGNED                             |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 3/19/1967   | 23c. NAME OF CEMETERY OR Landing Neck   | Vemetery E   | ocation (City or Town)                              | (County) (State)                        |
| 24. FUNERAL DIRECTOR  MALLO IS OF TOURS   | n & Im East                             | MARC 2 OF 19   | 167 Clianta   | Judge.                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

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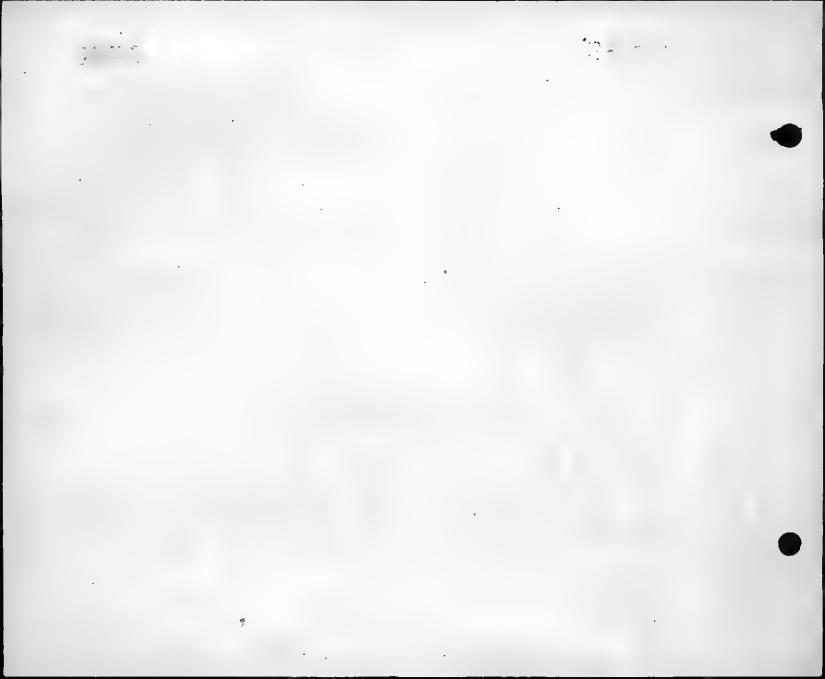
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| -             | OLKIII IOAT  | L OI BEATH  |
|---------------|--|---|
| 1,            | PLACE OF DEATH a, COUNTY   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) |
|               | 1 0 11- 1-   | MISPALAND DECONTROL TOUT  |
| -             | b. CITY OR TOWN (if outside corporate limits,   C. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (Is outside corporate limits, write RURAL and give nearest town)      |
|               | write RURAL and give nearest town)   |   |
| -             | Easton 22 hr.  | 1)ENION 15.2  |
|               | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   | d. STREET ADDRESS 6. IS RESIDENCE ON A FARM?  |
|               | Memorial Hospital  | YES NO M  |
| 3.            | NAME OF First Middle   |   |
|               | O CANA DE DESERVA  | DF 2 3  |
| 5.            | SEX Le COLOR DE PROCES   | By DATE OF BIRTH 9. AGE (In years   IFUNDER 1 YEAR   IF UNDER 24 ARS                  |
|               | WEATH WHITE  | last birthday) Months Days Hours Min.   |
| 100           | WIDOWED DIVORCED   | 34 mg 11, 1012 /4 yrs.  |
| du            | a. USUAL OCCUPATION (Give kind of work done   10b. KIND OF BUSINESS OR INDUSTRY   INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?      |
|               | at home  | (MORYLAN)   |
| 13            |  | 14. MOTHER'S MAIDEN NAME  |
|               | UR. 160S, GREENLEY   | NELLE CLARK   |
| 15            | 5. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17.   | INFO@MANT Address .   |
| CA            | es, nq, or unkown) (If yes give war or dates of service)   | NAS R CHARRENCH ONTO  |
|               | 100  | ONDI W. CHIEN ADMON JEWIN   |
|               | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  | INTERVAL BETWEEN ONSET AND DEATH  |
|               | PART I. DEATH WAS CAUSED BY:   | ear Marcher minietiste  |
|               | 4201 DUE TO ATO  | 77 11 0   |
|               | Conditions, If any, which ) all conditions of the condition of the conditions of the conditions of the conditions of the | edis Kontro VAIC  |
|               | gave rise to immediate (   | 0-001   |
|               | underlying equal fact  |   |
| 8             | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA   | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY             |
| CERTIFICATION | E 7 . 104 1150   | PERFORMED?  |
| I S           | Capeliere Her Sup  | YES NO 💆  |
| E.            | 206. DESCRIBE HOW INJURY OCCU<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | RRED. (Enter nature of injury in Part I or Part II of Item 18.)                       |
|               |  |   |
| MEDICAL       |  | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State)                        |
| 8             | Hour a.m.   While   Not While   factor   | ry, street, office bldg., etc.)   |
| 2             |  | 2 2 / 10/21-3-13 10/2 /11-11-11-11-11-11-11-11-11-11-11-11-11-                        |
|               | 21. I certify that (I) (this hospital) attended the deceased from  | 196 to 196 that (I) (we) last   |
|               | saw the deceased alive on 19 and that  | death occurred at 65 M, from the causes and on the date stated above.                 |
|               | VIIIAMANA MOONEY S. A.   | ATTENDING MED. STAFF 220. DATE SIGNED   |
| 1             | M.D  | PHYS. PHYS. DIRECTOR PHYS. D 24 6   |
|               | Property M. Bull   | 22d. ADDRESS  |
|               | 1 forgin ware go   | Minibian mg   |
| 232           | BURIAL, CREMATION, 230. DATE THEREOF 23C. NAME OF CEMETERY   | OR CREMATORY 23d. LOCATION (City, town or county) (State)                             |
|               | 1200 CDW [ Input 5 1' UP ! 1) 55 M 1   | ON NEWION MD  |
| 24            | ADDRESS ADDRESS  | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                                    |
|               | ( harby work 1 le for  | DAMAR 29 1967 Johnson Judge   |
| -             | 1,000  | - I WHAT I WOULD I  |

WHISTONS I LEED WITH ADMIS - BELLEN YERRESTER - CENTER -ATTES ( - HOWER PARTY ) PER THE NOT WE (THE DOMEST

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #11 infor. Item #23b.c & d requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) filled in by the funeral papers. Pages-1-and a. COUNTY after MARYLAND LENGTH OF STAY IN 16 CITY OR TOWN (If putside carporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carporate limits write RURAL and a ve negrest fown! hin 72 haurs IS RESIDENCE ON A FARM? d NAME OF HOSPITAL (If not in haspital, give, street address) d. STREET ADDRESS YES NO T DATE 3 NAME OF Middle Month Day Year remave carban WIT First Lost physician and completely DECEASED 19 6 Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6 COLGAR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Days Hours any WIDOWED DIVORCED 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a USI-AL OCCUPATION (Give kind of work done BIRTHPLACE (County & State, or faceion cauntry) and in o COUNTRY 2 please during most of working life, even if retired) INDUSTRY Chestertown. Kent 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, hen signed by the attending burial-transit permit. Th 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) [(If yes give war ar dates of service) INFORMANI 16. SOCIAL SECURITY NO. Address CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) attending physician. DHE TO Canditians, if any, which gave (b) rise to immediate cause (a). DUE TO stating the underlying couse as the has been last. WAS AUTOPS PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO TO FUNERAL DIRECTOR: After this certificate by the haspital ar 20g ACCIDENT WAS UNDERLYING [3] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL (County) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (Stote) factory, street, affice bldg, etc.) Haur a.m. Nat While While 19 at work at wark shauld be 2]. I certify that (I) (this hospital) attended the deceased fram ta. \_, that (I) (we) last be retained director, page 3 should should be filed with the and that death accurred at 42 M, fram causes and an the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Sandtown Cemetery Hillsboro Talb. Co.Md. 25g. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



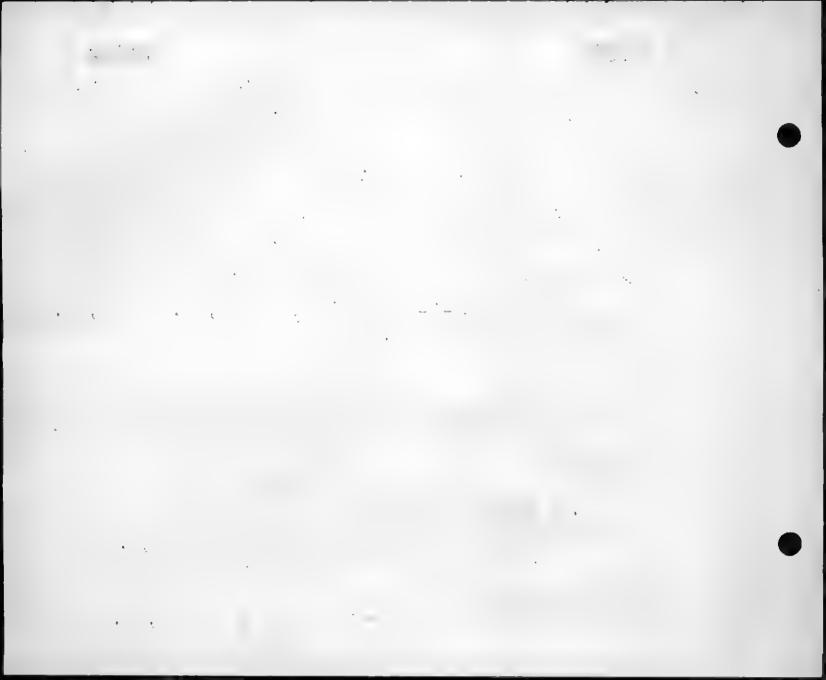
# M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| L             | 04232   | CERTIFICATE                         | OF DEATH   | 0  | 4232   |
|---------------|---|-------------------------------------|--|--|--|
| 1             | PLACE OF DEATH O COUNTY TAILBOT   | MARYLAND                            | o STATE Maryl  |  | Talbot   |
|               | b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  A-S-A-S-A-S-A-S-A-S-A-S-A-S-A-S-A-S-A-   | c. LENGTH OF STAY IN 1b             | Tilgh  | de carporote limits, write RURAL<br><i>MOI</i> L |  |
|               | d NAME OF HOSPITAL OR INSTITUTION (If not in )  | tospitol/give street oddress)       | d. STREET ADDRESS  |  | B, IS RESIDENCE<br>ON A FARM?<br>YES NO              |
|               | NAME OF DECEASED (Type or print)  A44  First  | Belle Cu                            | mmings   | OF DEATH   | Doy Year  19 6 7  IF UNDER 1 YEAR   IF UNDER 24 HRS. |
|               | Female white w  | IDOWED DIVORCED                     | 5/7/1897   | 69 birthdoy)                                     | Months Days Hours Min                                |
| dυ            | p. USJAL OCCUPATION (Give kind of work done<br>r pg most of working life, even if retired)  TO USE SUNDAY  FATHER S. NAME | 10b KIND OF BUSINESS OR<br>INDUSTRY | 11 BIRTHPLACE (County & S  Talbot Ma.  14. MOTHER'S MAIDEN NAI | ruland.  | 12 CITIZEN OF WHAT COUNTRY?                          |
| 1             | Addison Larrimore   | LV cocht croppiy to                 | Nannie Nea   | vitt   |  |
|               | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>es, no, or unknown) (If yes give wor or dotes af serv<br>no                    | <sup>(10)</sup> 218-18-4533   Re    |  | ings, Sr. 7il                                    |  |
|               | 18. CAUSE OF DEATH (Enter only one couse pe<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)                         | Cell out (a), (b), od (c).)         | Lavettoir  |  | INTERVAL BETWEEN<br>ONSET AND DEATH                  |
|               | Conditions, if ony, which gave inse to immediate cause (a), DUE TO  | <i>l'</i>                           |  |  |  |
|               | stoting the underlying couse (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRI  | RITING TO DEATH RIT NOT PELATED TO  | THE TERMINAL DISEASE CONDI                                     | TION GIVEN IN PART 1(a)                          | 19. WAS AUTOPSY                                      |
| CERTIFICATION | 200 ACCIDENT WAS UNDERLYING   | 205. DESCRIBE HOW INJURY OCCURRED   |  |  | PERFORMED? YES NO                                    |
|               | OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Day, Year                |                                     | CE OF INJURY (Home, form,                                      | 20f. (City or town)                              | (County) (State)                                     |
| MEDICAL       | Hour o.m.<br>p.m. 19  | While Not While facts               | ory, street, office bklg., etc.)                               |  | , 19, that (i) (we) lost                             |
|               | 21   certify that (i) (this hasping sow the deceased dive on 2  |                                     | t death accurred at 🖊  |  | nd on the date stated above.                         |
|               | 22c. PHYSICIAN'S  | M.I                                 |  | ED. RECTOR PHYS.                                 | 6Manh 67   |
| 23            | NAME (Type) E C C C C C C C C C C C C C C C C C C   |                                     |  | 23d. LOCATION (City or Town                      | (County) (State)                                     |
| 2             | BMEYAL (Specify) 3/8/1967 4 FUNERAL DIRECTOR  | Pilarim Holi                        | a - 25q. RECD B  |  | STRAR'S SIGNATURE                                    |
| 1             | Francia hi Verman   | 1204 CHELAYING                      | DATECTIE   | 8 1967 gcc                                       | carles Judge.  |

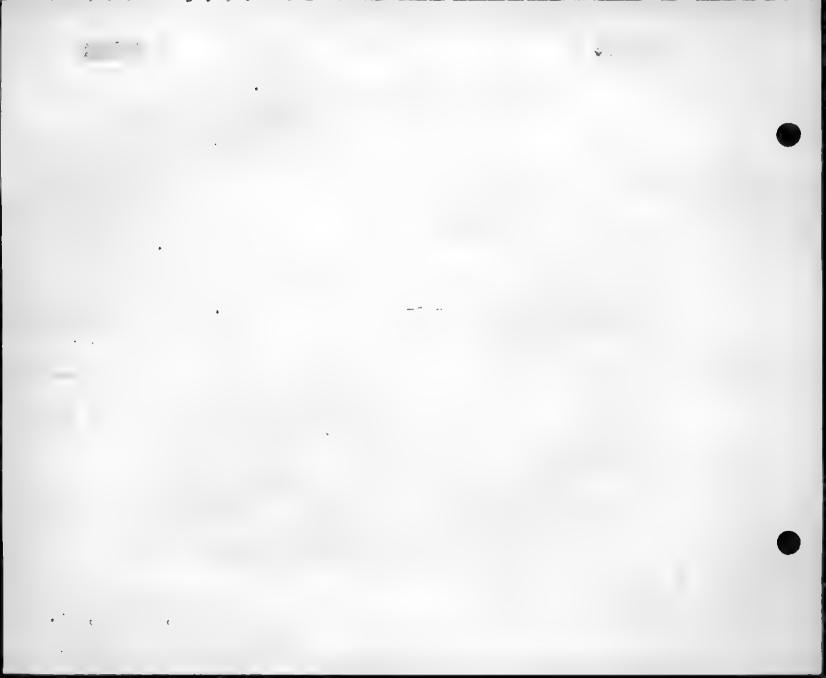
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove called papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or remayal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician

VR A15 (4) 20 M 1/66



# MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| .V  | VI)   |     | 1             | 04233  |                          |                            | CERTIFICATE             | OF         | DEATH                 |                      | 0                 | 4233                    |                            |
|---|---|-----|---------------|--|--------------------------|----------------------------|-------------------------|------------|-----------------------|----------------------|-------------------|-------------------------|----------------------------|
| #a  | and y<br>death  | ſ   |               | LACE OF DEATH  |                          |                            |                         |            | TATE                  | Where deceased liv   |                   |                         |                            |
| D   | funeral<br>1 and<br>ter death   |     | a             | COUNTY   | alhat                    |                            | MARYLAND                | 0. 3       | Md.                   |                      | b. COUNTY         | Talbo                   | t                          |
| ŧ   | ges<br>off  | 1   | Ь             | CITY OR TOWN (IF OU  | tside corparate limits,  | c LEN                      | GTH OF STAY IN 16       | < € CITY   | OR TOWN (If ou        | itside corparate lin | nits, write RURAL | and give nearest        | rawn)                      |
| SIO.  | Pa  |     |               | write RURAL and give   | s hearest tawn;          |                            | 4days)                  |            | Easto                 | on                   |                   | 1                       | ,                          |
| Ę.  | i   |     | d             | NAME OF HOSPITAL O   | R INSTITUTION (If not    | ın haspitai, give stre     | 4 4 4                   | d. STR     | EET ADDRESS           |                      |                   | 9                       | IS RESIDENCE<br>ON A FARM? |
| n 24  | Pop de la   |     |               | me   | morial                   | Hospi                      | tal                     |            | South                 | Clifto               | n                 | YE                      |                            |
| <u>#</u>  | <b>子6章</b>  | - 1 |               | IAME OF  | First                    |                            | Middle                  |            | Lost                  | 4. DATE<br>OF        | Month             | Doy                     | Year                       |
| ><br>-0   | arb int   |     | - {           | Type or print)   | WAT                      | te.                        |                         |            | Rley                  | DEATH                | MARC              | h 18                    | 1967                       |
| :ute  | we de   |     | 5. 5          | EX6.   | COLOR OR RACE            | 7. MARRIED 🔼 I             | NEVER MARRIED   B       |            | OF BIRTH              | las                  |                   | UNDER I YEAR anths Days | IF UNDER 24 ARS Hoors Min  |
| ×e  | d co  |     | _/            | male.  | White                    | WIDOWED                    | DIVORCED                |            | - 30-                 | 85 8                 | Yrs.              | ,                       |                            |
| 96  | an in on  |     | 10a           | USUAL OCCUPATION (Giv  | e kind of work done      | 10b. KIND OF 6<br>INDUSTRY |                         |            |                       | & State, or fareign  |                   | 12. CITIZEN OF V        |                            |
| <u>e</u>  | sase  |     |               | galesman   | , von in iem vaj         | III DOSTRI                 | Milling                 |            |                       | sboro,               | Ill.              |                         | USA                        |
| ٩   | al pla  |     | 13.           | FATHER S NAME  |                          |                            |                         |            | OTHER'S MAIDEN        |                      |                   |                         |                            |
| cert  | hen<br>nav  | l   |               | Lemuel   | Darley                   |                            |                         |            |                       | lint Da              |                   |                         |                            |
| €   | ding.   |     |               | WAS DECEASED EVER IN , na, ar unknawn) (If y                           |                          | convica)                   |                         | NFORMA     |                       |                      | Address           |                         |                            |
| qeo   | irmi<br>r, ar   |     | no            |  | ssgive was or deres or . | 305-0                      | 05-5747 M               | rs.        | Lillia                | an L. D              | arley,            | South                   | Clifto                     |
| law requires that the death certificate be executed within 24 haurs after death<br>nding physician. | signed by the attending physician and campletely fulled in by the fun<br>burial-transit permit. Then please remave carbon papers. Pages 1<br>burial, crematian, ar remaval, and in any event, within 72 haurs after |     |               | 1B. CAUSE OF DEATH<br>PART I. DEATH W                                  | AS CALISED BY            | NII.                       |                         |            |                       |                      |                   | INTER<br>ONSE           | AND DEATH                  |
| 불 등   | by<br>ran   | - 1 |               | 1.03X  | IMMEDIATE CAUSE (o       |                            |                         | 1 -        |                       | . #                  |                   |                         |                            |
| quires the<br>physician.  | al,   | - 1 | - 1           | Conditions, if any, whi  |                          | dun                        | ic Alestruct            | we         | unopal                | ley                  |                   | (3/                     |                            |
| <u>.</u>  | Sign<br>Buri  |     |               | rise to immediate co   | use (o).                 | , —                        |                         |            |                       | /                    |                   |                         |                            |
| 7 P   | the true  |     |               | stating the underlyin  | g couse                  | ()                         |                         |            |                       | •                    |                   |                         |                            |
| 말한  | has been<br>se as the<br>h priar ta   | - 1 | - 1           | _  |                          |                            | H BUT NOT RELATED TO T  | HE TERM    | INAL DISEASE COL      | NDITION GIVEN IN     | PART I(o)         | 19. V                   | VAS AUTOPSY                |
| The state   | use i   | e-  | ATION         | THE II. DITTER STOTE   |                          |                            | some dere to            |            |                       |                      |                   | P                       | ERFORMED?                  |
| <b>G PHYSICIAN</b><br>the haspital o  | certificate has been<br>hed far use as the<br>it. af Health priar ta  |     | CERTIFICATION | 20o. ACCIDENT WAS UNI<br>OR CONTRIBUTING ☐ C<br>(IF EITHER, NOTIFY MED | AUSE OF DEATH            | 205. DESCRIBE I            | IOW INJURY OCCURRED. (  | Enter no   | ture of injury in     | Part I ar Part II a  | fitem 1B.)        |                         | ,                          |
| 돌물  | this cert<br>detached<br>e Dept. a  | - 1 | MEDICAL       | 20c TIME OF INJURY   |                          | 20d. INJURY O              |                         |            | URY (Hame, farn       |                      | y or town) -      | (County)                | (Stote)                    |
|   |   |     | 윟             | Haur a.m.<br>p.m.  | 19                       |                            | at While Garta          | ory, stree | t, affice bldg , etc. | )                    |                   |                         |                            |
| 高麗  | Sto Sto   |     | ı             | 21 L certify t   | hat (1) (this hasp       | ital) attended th          | e deceased fram         | 1/24       | 4                     | 1965 , ta_           | Flee              | , 19 <u>67</u> , tha    | t (I) (we) la:             |
| E E   | # Se #  | - 1 | - 1           | saw the deced  | sed alive an/            | 8 dear                     | 19 <u>67</u> , and that | death      | accurred at           | 90M, fr              | om causes and     | an the date             | stated abave               |
| ATT<br>egin   | 당%≢   | - 1 |               | 22a. SIGNATURE   | 1 01                     | /                          |                         |            |                       |                      | STATE             | 22b. DATE SIGNE         |                            |
| 8 °   | DIRECTOR<br>ge 3 shaul<br>led with th   |     | - [           | /h   | cers from El.            | eri, an-                   | M.D                     | ). PHY     |                       | MED DIRECTOR         | PHYS.             | 20 dias                 | 47                         |
| TO HOSPITAL OR ATTENDIN<br>Page 4 may be retained by  | TO FUNERAL DIRECTOR: After this ce director, page 3 should be detache should be filed with the State Dept.  |     |               | 22c PHYSICIAN'S<br>NAME (Type)   | HURSTON                  | HARR                       | SON                     | 220        | Carte                 | , day                | laur              | ·                       |                            |
| 0SP<br>3-4  | E SE  |     | 230           | BURIAL CREMATION,  | 23b DATE THER            |                            | NAME OF CEMETERY OR (   | REMATO     | IRY                   | 23d LOCATIO          | N (City or Town)  | (County)                | (State)                    |
| Hő  | F   |     | ľ             | REMOVAL (Specify)  | 3/21/                    |                            | Springhi                |            |                       |                      | on, Ta            |                         | , ,                        |
| =   | H   | y   |               | FLINERAL DIRECTOR  |                          | -                          | ADDRESS                 |            | 250 RECT              | D RY REGISTRAR       |                   |                         |                            |



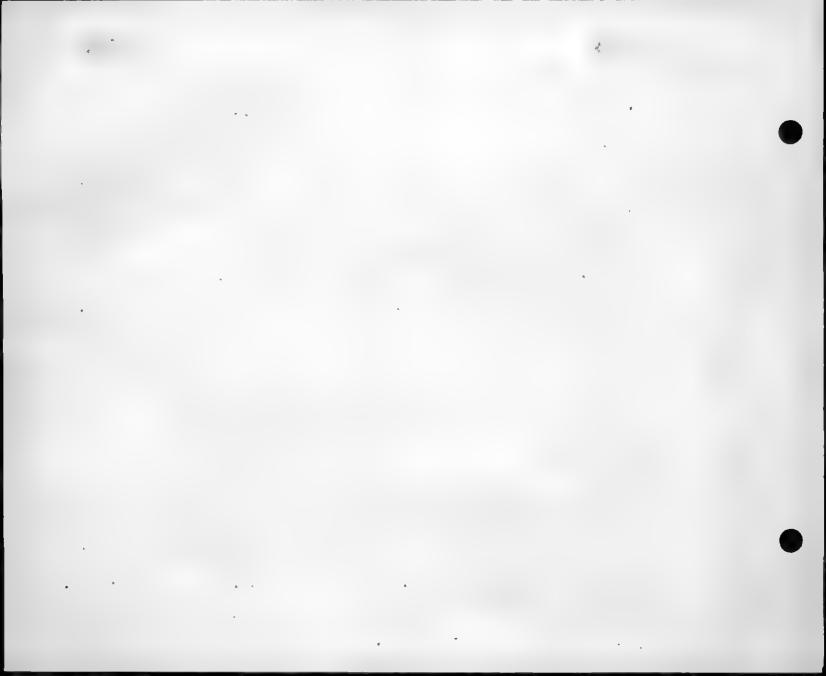
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|                 | 04234  |   |                             | CERTIFICATE                               | OF DEATH  |                        | -                                    | 04234                              |  |
|-----------------|--|---|-----------------------------|---|---|------------------------|--------------------------------------|------------------------------------|--|
|                 | PLACE OF DEATH O COUNTY Talbo  | t   | <u></u>                     | MARYLAND                                  | 2. USUAL RESIDENCE (V                                       | Where deceosed<br>Land | l lived, if institutio<br>b. COUNT   |                                    |  |
|                 | b. CITY OR TOWN (If outside write RUPAL and give ne  | corporate limits,<br>orest town)                |                             | life                                      | c. CITY OR TOWN (If ou                                      | itside corporate       | limits, write RURA                   | é                                  | 20-1   |
|                 | d. NAME OF HOSPITAL OR IN  | STITUTION (If not in 1                          | nospitol, g                 | ive street oddress)                       | d STREET ADDRESS  |                        |                                      | 1                                  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO          |
|                 | NAME OF DECEASED (Type or print) Ma  | First   |                             | Middle Etta E                             | Lost<br>a <b>son</b>  | 4 DATE<br>OF<br>DEATH  | Month<br>Ma <b>rc</b> h              | 25,                                |  |
|                 |  |   | MARRIED<br>IDOWED           | NEVER MARRIED   8                         | 6-7- I900   |                        | AGE (In years last birthdoy) 66 yrs. | Months Doys                        | IF UNDER 24 HRS.<br>Hours Min.                   |
|                 | o USUAL OCCUPATION (Give kir<br>ring most of working life even<br>NOUSEW   |   |                             | ND OF BUSINESS OR<br>DUSTRY               | 11 BIRTHPLACE (County Talbot-                               |                        | -                                    | 12. CITIZEN OF<br>COUNTRY?<br>US A | WHAT   |
| 13.             | John H. I  | McDaniel  |                             |   |   | name<br>e <b>Wil</b> s | son                                  |                                    |  |
| 1S.<br>(Ye      | es, no, or unknown) (If yes gir  | ARMED FORCES?<br>ve war or dotes of serv        | irali                       |   | nformant<br>Solomon Ea                                      | ason                   | Address<br>Trap                      | pe, Md.                            |  |
|                 | PART I. DEATH WAS O<br>IM<br>5/X<br>Conditions, if ony, which g<br>rise to immediate couse<br>stating the underlying co<br>lost. | MEDIATE CAUSE (o)  DUE TO  OVE (b)  (o), DUE TO |                             | anima .                                   | of the  | olim                   | well                                 | /0                                 | ISET AND DEATH                                   |
| ATION           | PART II. OTHER SIGNIFICAN  | T CONDITIONS CONTR                              | IBUTING T                   | O DEATH BUT NOT RELATED TO T              | HE TERMINAL DISEASE CON                                     | NDITION GIVEN          | IN PART I(o)                         |                                    | WAS AUTOPSY<br>PERFORMED?<br>'ES NO 🌠            |
| L CERTIFICATION | 2Do. ACCIDENT WAS UNDERL'<br>OR CONTRIBUTING CAUSE<br>(IF EITHER, NOTIFY MEDICAL   | OF DEATH  | 20b. DES                    | CRIBE HOW INJURY OCCURRED                 | Enter noture of injury in                                   | Port I or Port I       | I of item 18.)                       |                                    |  |
| MEDICAL         | 20c TIME OF INJURY Mon<br>Hour o.m.<br>p.m.  | th, Day, Yeor<br>19                             | 20d. IN<br>While<br>of work | Not While focto                           | E OF INJURY (Home, form<br>ory, street, office bldg , etc.) |                        | (City or town)                       | (County)                           | (Stote)  |
|                 | saw the deceased   |   | attend                      | ed the deceased fram _ch_19_6_7, and that |   |                        |                                      | nd an the dat                      | hat (I) ( <del>we</del> ) las<br>te stated abave |
|                 | 22o. SIGNATURE   | Car   | ne                          | A. M.                                     | 1111111   | MED.<br>DIRECTOR [     | STAFF PHYS.                          | 3-28                               | 1ED<br>2-67                                      |
|                 | 22c. PHYSICIAN'S<br>NAME (Type) Sto  |   |                             | у, М.Д.                                   | · · · · · · · · · · · · · · · · · · ·                       | P.O. Bo                |                                      | aston, M                           | d.   |
|                 | BURIAL, CREMATION,   | 3-29-19   |                             | Paradise                                  |   | Trar                   | שמו                                  | Talbot                             | Md.  |
| 24              | 4. FUNERAL DIRECTOR  | 4 . 7 7   | Tro                         | ADDRESS Md                                | 25ga RICE   | BX REGISTRA            | R <sup>+</sup> 2Sb. REG              | ISTRAR'S SIGNATUL                  | KE   |

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death **TO FUNERAL DIRECTOR:** After this cerificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove-carban papers. Pages 1 applied by the State Dept. of Health priar ta burial, trematian, or remaval, and in any event, within 72 haurs after activities. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 20 M 1/66



|  |               | Division  | n of STATISTICAL RESEA  | RCH AND RECORDS, 301                    | W. PRESTON STRE  | ET, BALTIMORE, MARY                         | LAND 21201  |
|--|---------------|---|---|---|--|---|---|
| Ma:  |               | 04235   |   | CERTIFICATE                             | OF DEATH   |   | 04235   |
| r doth   |               | PLACE OF DEATH  | 1bot.   | MARYLAND                                |  | there deceased lived, if institution b. COU | tion Residence before odmission) NTY Careline                     |
| haurs after<br>in by the fur<br>rs. Pages 1<br>2 haurs after   |               | CITY OR TOWN (If outs de<br>write RURAL and give ne                             | corporate limits,   | CLENGTH OF STAY IN 16                   | c CITY OR TOWN (If our Rural Gre                             | tside corparate limits, write Rt            | IRAL and give nearest town)                                       |
| n 24 haurs of illed in by the papers. Paginin 72 haurs   |               | 4.7   | STITUTION (If rot in haspital gr                                      | 5 days.                                 | d. STREET ADDRESS  | Nene  | e 15 RESIDENCE<br>ON A FARM?                                      |
| hin 2<br>filled<br>pap<br>thin   | 3             | MAME OF ,   | etro real   | ^ Middle                                | Lost   | 4 DATE Mor                                  | YES NO Day Year   |
| oletely to carban ent, with  |               | Type or print)  | (-linton  | J. Edwa                                 | erds.  | OF<br>DEATH                                 | 19 19 67  |
| be executed within and and campletely fille in any event, within   | /5<br>1       | lale Car  | OR OR RACE 7 MARRIED/   |   | B. DATE OF BIRTH<br>1-20-1900                                | 9. AGE (In years last buthday)              | IF UNDER 1 YEAR   IF UNDER 24 HRS.   Months   Days   Hours   Min. |
| that the death certificate be executed within 24 haurs after an.  by the attending physician and campletely filled in by the fransit permit. Then please remave carbon papers. Pages crematian, ar remaval, and in any event, within 72 haurs after a free matter.   | dug           | USUAL OCCUPATION (Give king most of working life, even                          | if retired) IND   | D OF BUSINESS OR<br>DUSTRY<br>PRINCE    | Maryla   |   | 12. CITIZEN OF WHAT COUNTRY?                                      |
| physic<br>en ple<br>aval, c  |               | FATHER'S NAME   | wo wal a  |   | 14. MOTHER'S MAIDEN N  | Greenlee                                    |   |
| at the death cer<br>the attending p<br>nsit permit. The<br>matian, ar rema   | is.           | WAS DECEASED EVER IN U.S. is, na, ar unknown) (If yes gir                       | ARMED FORCES? 16. S   | OCIAL SECURITY NO 17. I                 | NFORMANT   | Add   | ress  |
| e dea<br>atten<br>sermi'   | (10           | N•  | ] 2]  | 17-36-1094                              | Pauline  | Edwards G                                   | reensbere Md.   |
| that the death certific<br>an.<br>by the attending physiransit permit. Then piccemation, ar remayal,   |               | PART 1. DEATH WAS 0   | ter only one couse per line for (<br>CAUSED BY.<br>MMEDIATE CAUSE (a) | (o), (o), and (c).)                     |  |   | ONSET AND DEATH   |
| 10 TO TO TO  |               | Conditions, if any, which g   | DUE TO  | buirlas neples                          | selerosin  |   | (?/   |
| 주요 is 교실   |               | nse to immediate couse<br>stating the underlying co<br>last.                    | (a), ( DUE TO   |   |  |   |   |
| ICIAN: The law rateding of a category of the c | ATION         |   | et conditions contributing to   |   | THE TERMINAL DISEASE CON                                     | DITION GIVEN IN PART 1(0)                   | 19. WAS AUTOPSY PERFORMED? YES NO                                 |
| HYSICIAN:<br>haspital ar<br>certificate<br>iched far u   | CERTIFICATION | 20g. ACCIDENT WAS UNDERU<br>OR CONTRIBUTING CAUSE<br>(IF EITHER, NOTIFY MEDICAL | E OF DEATH  | CRIBE HOW INJURY OCCURRED.              | (Enter nature of injury in I                                 | Part I ar Part II af item 18.)              |   |
| PH he he he he he he he he betac   | MEDICAL       | 20c TIME OF INJURY Man<br>Hour a.m.<br>p.m.                                     | nth, Day, Year 20d. IN.<br>While<br>at work                           | Nat While at wark                       | CE OF INJURY (Hame, farm<br>ary, street, affice bldg , etc.) |   | (County) (State)  |
| R TO A P P   |               | 21. I certify that saw the deceased   | t (I) (this hospital) attend  | led the deceased fram<br>19 47, and tha | the nule 1   | 9 40 to 19 les<br>5 35 M, from causes       | and an the date stated above.                                     |
| OR ATTENI<br>be retained<br>DIRECTOR: /<br>Ie 3 shauld<br>ed with the  |               | 22a SIGNATURE   | 0/  | M.                                      | ATTENDING -  | MED. STAFF DIRECTOR PHYS.                   | 22b. DATE SIGNED  20 Kear 67                                      |
| May RAI   Poge fill be |               | 22c. PHYSICIAN S<br>NAME (Type)   | URSTON HAR  | PRISE N                                 | 22d. ADDRESS   | Pan hary &                                  | Peru  |
| O HOSPITAI Page 4 may O FUNERAL director, pag should be fi   | 230           | BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF   | 23c NAME OF CEMETERY OR                 |  | 23d LOCATION (City or T                     | , , , , , , ,   |
| 5 5 5 W  | _             | burial  | 3-22-67   | Greensbor                               | Dec Decin  | Greensb                                     | oro, Md.  |

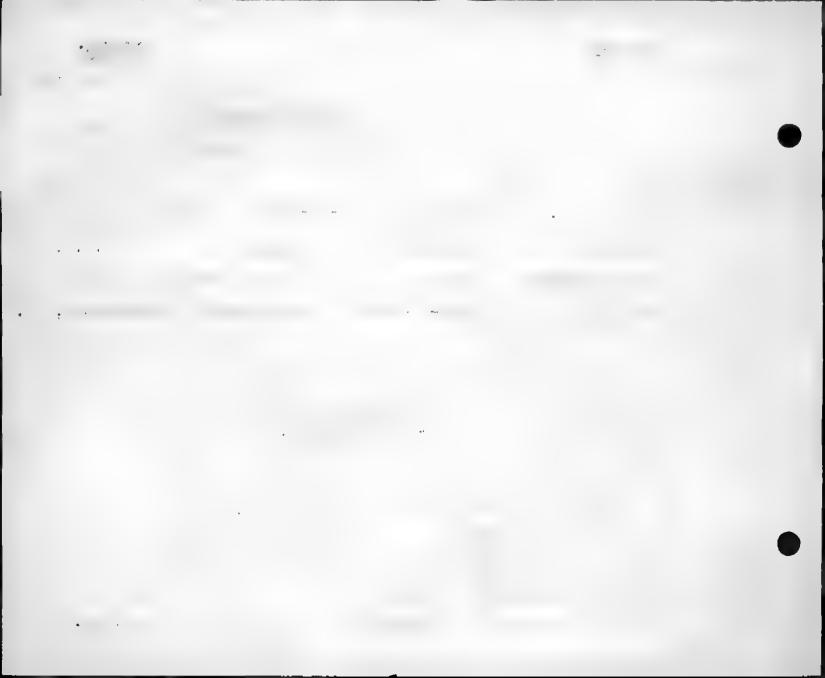
VR A15 (4) 20 M 1/66

BURIAL, CREMATION, REMOVAL (Specify) BUT1 a1 FUNERAL DIRECTOR

Greensbore ADDRESS

Greensboro
250 REC'D BY REGISTRAR
MAR 2 3 1967

(County) (Stote)



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

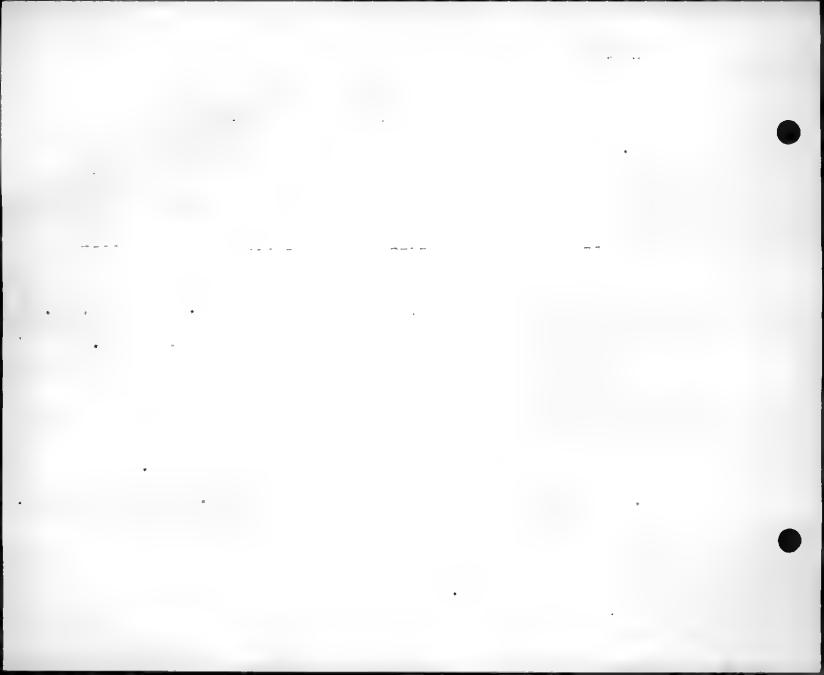
04236 ny delay is 5 may be retained for your files

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages land2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any eventmentment in 12 hours after death PM3 Pag in penci in Item 18 Give Pages 1, 2, and 3 tg the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours ofter death If necessory, please execute the certificate, writing the word "pending"

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| a. COUNTY  | Talbot   | MARYLANO                        | a. STATE Don                     | ngylvania b (OUNT)                            |   |
|--|--|---------------------------------|----------------------------------|---|---|
| witte RuRAL o                                    |  | c LENGTH OF STAY IN 1b          | 13                               | autside corparate limits, write RURA.         | hia   |
| Rt. #  | ITAL OR PASTITUT ON (If not in has)                      |                                 | d STREET ADDRESS                 | N. Tenth Street                               | e IS RESIDENCE<br>DN A FARM?<br>YES NO                |
| 3 NAME OF<br>DECEASED<br>(Type or print)         | First<br>XXXXXXXXXXXX                                    | JOSEPH Maddle                   | FREE                             | 4 DATE Month<br>OF March                      | 11 <sup>0 dy</sup> 19 <sup>6</sup> 7                  |
| Male   | 6 CO.DR DR RACE 7 MAR Negro W.DO                         | WED D, VDRCED                   | B. DATE OF BIRTH 190             | 7 A Se (In years A Se unitary)                | FUNDER LYEAR IF UNDER 24 HRS<br>Manths Days Haurs Min |
| during mast af warkin                            |  | OB K ND OF BUSINESS OR INDUSTRY |                                  |   | 12 CIT ZEN OF WHAT COUNTRY?                           |
| 13 FATHER'S NAME                                 | Unknown  |                                 | 14 MOTHER'S MAIDE                |   |   |
| IS WAS DECEASED E                                | WED IN ITS ADMED CODICES                                 | 16. SOC AL SECURITY ND.         | 17 INFORMANT                     | CNOWN Address                                 |   |
| (Yes, no, ar unknown Unknown                     | (If yes give war at dates af service)                    | ?                               |                                  | Records. Camb                                 |   |
| rise to immedia                                  | ny, which gave (b) (b)                                   | TING TO DEATH BUT NOT RELATED   | TO THE TERMINAL DISEASE          | CONDITION GIVEN IN PART I(a)                  | 19 WAS AUTOPSY PERFORMED?                             |
| S SOO SYTERNA O                                  | CA SEWAS To  | Db. DESCRIBE HOW INJURY OCCUR   | DED /feature actives of annual   | to Deed, or Deed (Lod story 1D.)              | YES X NO  |
| 20g EXTERNAL GAUGE OF DEATH 20c T ME DF N Haur C | DATR BUTING 🗀  |                                 | ,                                | ding in raod.                                 |   |
| 20c T ME DF N                                    | IJORY Manth, Day Year                                    | 20d INJRY DCCURRED 20e          | PLACE OF INJURY (Hame, f         | arm, 20f (City or tawn)                       | (Caunty) (State)                                      |
| 7.2UP  | M 3/11/67  | While Nat While at wark at wark | factory, street, affice bldg , e |   | e Talbot Md.  |
|  | ify that I took charge of th<br>alted from Natural couse |                                 | Suicide, Homici                  |   | , , ,   |
| ACTUAL<br>SIGNATURE                              | Later 2  | eroce &                         |                                  | MEDICAL EXAMINER                              | 22. DATE SIGNED                                       |
| EXAMINER'S<br>NAME (Type)                        | John Mace  | Jr.                             |                                  | DICAL EXAMINER XX reet, city, town_ar county) | 3/12/67   |
| 23a PURIAL CREMAT                                | TION, 23b DATE THEREOF                                   | 286 NAME OF CEMETERS            | OR CREMATORY OF                  | 23d OCATION (City or Town                     | Coro Co   |
| 24. FUNERAL DIRECT                               | TOR /  | ADORESS                         | 25a. R<br>DATE                   |   | STRAR'S SIGNATURE                                     |

VR A15ME (5)



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

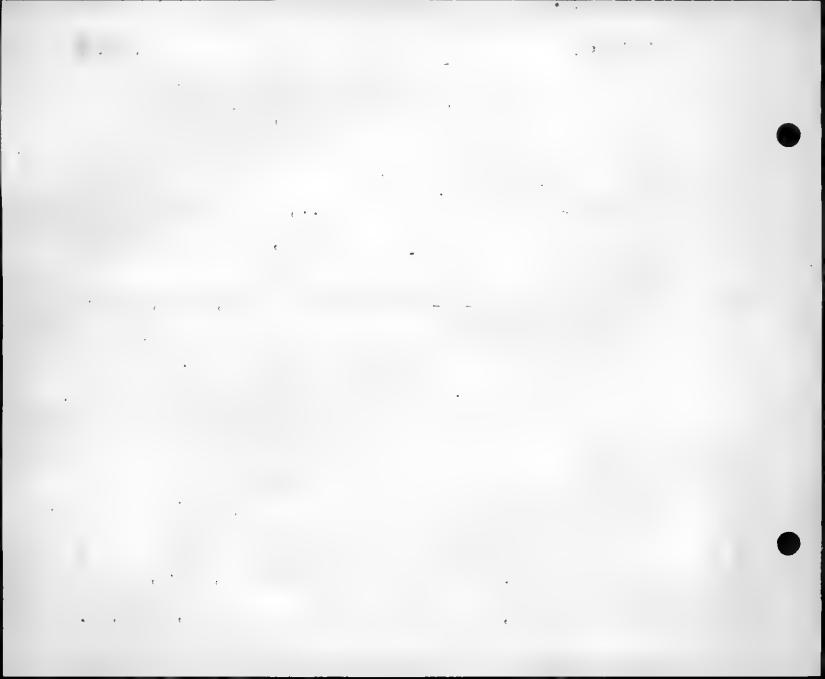
|     |                       | 04237   |   | CERTIFICAT                  | TE OF DEATH   |                                       | 04236   |
|-----|-----------------------|---|---|-----------------------------|---|---------------------------------------|---|
|     |                       | PLACE OF DEATH O COUNTY   | 51+                                       | MARYLAND                    | 2 USUAL RESIDENCE (W  | there deceased lived, if institution  |   |
| ı   | ŀ                     | b. CITY OR TOWN (If outsid  |   | c LENGTH OF STAY IN 1b      | c. CITY OR TOWN (If ou  | rside corporote limits, write RURA    | L and give nearest town)                                  |
|     |                       | write RURAL and give n  | eorest rown)                              | D.O.A.                      | Easten, M   | aryland                               | 2 -1  |
|     | (                     | d, NAME OF HOSPITAL OR I  | NSTITUTION (If not in hospital, o         | give street address)        | d. STREET ADDRESS   |                                       | e IS RESIDENCE<br>ON A FARM?                              |
| 4   |                       | Memor   | al Hospiz                                 | 0/                          | 110 Sout  | a Street                              | YES NO D  |
|     |                       | NAME OF A   | First ,                                   | Middle                      | cs Lost   | 4. DATE Month OF >                    | Doy Year  |
|     | (                     | (Type or print)   | argaret V                                 | irginia                     | treemen   | DEATH ->                              | 3 1967  |
|     | 5 5                   |   | OR OF RACE 7, MARRIED                     | NEVER MARRIED               | 8. DATE OF BIRTH  | 9. AGE (fn yeors                      | IF UNDER 1 YEAR IF UNDER 24 HR\$.  Months Doys Hours Min. |
|     |                       | male Neg  |   | DIVORCED                    | Mar.22,1919   | yrs                                   | 10 (171751) 05 148147                                     |
|     | l0o<br>dur            | usual occupation (Give k<br>no most of work notifie ever<br>Housewill           |   | ND OF BUSINESS OR<br>DUSTRY | Trappe, Ma  |                                       | 12. CITIZEN OF WHAT                                       |
|     |                       | FATHER'S NAME<br>Louis Smith  |   |                             | 14. MOTHER'S MAIDEN A   | Smith                                 |   |
| ľ   | 15.                   | WAS DECEASED EVER IN U.S.   | ARMED FORCES? 16                          |                             | . INFORMANT   | Address                               |   |
|     | (Te                   | s no, or unknown) (# yes o  | ive wor or dotes or service.              | <b>el- 7873</b>             | Memorial Hosp   | ital, Easton, l                       | Maryland  |
|     |                       | PART I. DEATH WAS   | MMEDIATE CAUSE (o)  DUE TO  gove (b)  (b) | FUTRICUL                    | AR FIRMAL INF   | relation<br>1 DISEASE<br>ARCTION      | INTERVAL BETWEEN ONET AND DETE                            |
|     | ATION<br>N            | PART II. OTHER SIGNIFICA  | NT CONDITIONS CONTRIBUTING T              | TO DEATH BUT NOT RELATED TO | O THE TERMINAL DISEASE CON  | DITION GIVEN IN PART 1(0)  ALCOPOLLIS | 19 WAS AUTOPSY PERFORMED? YES NO                          |
|     | MEDICAL CERTIFICATION | 200. ACCIDENT WAS UNDER<br>OR CONTRIBUTING (I CAUS<br>(IF EITHER, NOTIFY MEDICA | SE OF DEATH                               | SCRIBE HOW INJURY OCCURRE   | D (Enter noture of injury in I                                    | Port I or Port II of item 1B.)        |   |
|     | MEDICAL               | 20c. TIME OF INJURY Mo<br>Hour o.m.   |   | ☐ Not While ☐ f             | LACE OF INJURY (Home, form<br>actory, street, office bldg., etc.) | , 20f (City or town)                  | (County) (Stote)  |
|     |                       | 21. I certify the   | t (I) (this haspital) atten               | ded the deceased fram.      | Dec., 1<br>hat death occurred at                                  | M, fram couses a                      | nd on the date stated abave                               |
|     |                       | 220 SIGNATURE   | 07. Sy                                    | Son                         | M.D. PHYS.  | MED. STAFF DIRECTOR PHYS.             | 22b. DATE SIGNED -67                                      |
| · · |                       | 22c PHYSICIAN S<br>NAME (Type)  | CHARD F.TYSON                             |                             | G Lanweed   | Ave, Easton,                          | Maryland  |
|     | 230                   | BURIAL, CREMATION,<br>REMOVAL (Specify)   | 23b DATE THEREOF<br>Mar 7,1967            | 23c. NAME OF CEMETERY C     | or CREMATORY<br>Semetery  | Trappe, Tal                           |   |
|     |                       | FUNERAL DIRECTOR  | s an M                                    | ADDRESS                     |   |                                       | ISTRAR'S SIGNATURE  |
|     |                       | 1 6 by 6  | VII to                                    | well blown                  | DATE DATE   | MAR 6 1967                            | Whomber Jules   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death

Page 4 moy be retained by the hospital or ottending physicion.

VR A15 (4) 20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funders director, page 3 should be detached for use as the burial-transit permit. Then please (emaye carbon papers. Pages 3 kmg should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any everyt, within 72 hours after debt.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|  |  | 04238   | 1  | MEI                  | DICAL EXAMIN                         | IER'S    | CERTIFICATE OF  |   | 4237  |  |  |  |
|--|--|---|--|----------------------|--------------------------------------|----------|---|---|---|--|--|--|
|  | 1. PLACE OF DEATH  |   |  |                      |                                      |          | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) |   |   |  |  |  |
|  | /A/DO/   |   |  |                      | MARY                                 |          | Maryland Talbet COUNTY  |   |   |  |  |  |
|  | b CTY OR TOWN (If autside carparate limits write RURA, and give nearest tawn)                          |   |  |                      | c LENGTH OF STAY I                   | N 1b     |   | de carparate i mits, write RURA             | AL and give nearest tawn)                           |  |  |  |
|  |  | EASTON  |  |                      | DQA                                  |          | 1   | Easton, Maryland                            |   |  |  |  |
| 1  |  | d NAME OF HOSPITAL OR INSTITUTION (Finot in   |  |                      | asp ta give street address) HCSPITAL |          | Oswald Ct,  | e IS RES DENCE<br>ON A FARM?<br>YES NO      |   |  |  |  |
| \.   |  | NAME OF<br>DECEASED<br>(Type or pnnt)   | LOTT   | F M                  | Middle FRL                           | ELBIA    | A /   | OF DEATH 3                                  | Day Year<br>2- 19 6 7                               |  |  |  |
| )  | 5  | Fi male   | 6 COLOR OR RACE  | 7 MARRIED<br>WIDOWED |                                      |          | DATE OF BIRTH 4/17/25   | 9 AGE (In years<br>, ast brithday)<br>3 yrs | FUNDER I YEAR IF UNDER 24 HRS Months Days Hours Min |  |  |  |
|  | 10a<br>duri  | USUAL OCCUPATION  | (G,ve kind af wark dane<br>fe even if retired)                       |                      | KIND OF BUSINESS OR<br>INDUSTRY      |          | 11 BIRTHPLACE (State of Easten,   | fareign country)<br>Maryland                | 12 CITIZEN OF WHAT                                  |  |  |  |
|  | 13.  | FATHER'S NAME   |  |                      |                                      |          | 14 MOTHER'S MAIDEN NA   | WE  |   |  |  |  |
|  |  | Prester   | Freeman  |                      |                                      |          | Henriet   | ta Breeks                                   |   |  |  |  |
|  | 15<br>(Ye  | S WAS DECEASED EVER IN U.S. ARMED FORCES?  (es, na, ar unknawn) (If yes give war ar dates af serv   |  | service)             | ice) 16 SOCIAL SECURITY NO 17. II    |          | Memorial Hosp, Easton, Md.  |   |   |  |  |  |
| , -  |  | IB. CAUSE OF DE<br>PART I. DEAT   | ATH (Enter anly one cau<br>H WAS CAUSED BY<br>IMMEDIATE CAUSE<br>DUE | (a) <u>C</u>         | gr (a), (b), and (c))                | sk       | all feartur   | <i>-</i>                                    | INTERVAL BETWEEN ONSEL AND DEATH                    |  |  |  |
|  |  | Canditians, if any, which gove nse to immediate cause (a), stating the underlying cause last (c)  |  |                      |                                      |          |   |   |   |  |  |  |
| 4  | ATION  | PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  19 WAS AUTOPSY PERFORMED? YES P NO |  |                      |                                      |          |   |   |   |  |  |  |
|  | CERTIFICATION  | 200 EXTERNAL CA.<br>PR MARY OF CON<br>CAUSE OF DEATH.   | JSE WAS<br>ITRIBUTING []   | 20b E                | DESCRIBE HOW INJURY OF               |          | (Enter nature of injury in Pa<br>Cerr   | t I or Part II of tem 1B)                   |   |  |  |  |
| +  | MEDICAL  |   | RY Month Day Year  | 4.0                  |                                      | 20e PLAI | E OF INJURY (Hame, farm,<br>ary, street, affice b dg , etc )                          | 20f (City or town)                          | Talfort haylan                                      |  |  |  |
|  | 21   certify that   taak charge of the remains described above, held an Autopsy   Inspection   Inquiry |   |  |                      |                                      |          |   |   | ry 🗍 , and in my apinian                            |  |  |  |
| death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined mar |  |   |  |                      |                                      |          |   |   |   |  |  |  |
|  |  | SIGNATURE SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER [] 22. T  |  |                      |                                      |          |   |   | 22. DATE SIGNED                                     |  |  |  |
|  |  | EXAMINER'S NAME (Type) THUR STON HARRISON DEPUTY MEDICAL EXAMINER Address (Street, city, town, or count Cartan Heavy locks  |  |                      |                                      |          |   |   |   |  |  |  |
| 0  |  | BURIAL, CREMATIO<br>REMOVAL (Specify)   | Mar 6  |                      | 23c NAME OF CEME                     |          | E Cometery  | 23d LOCATION (City of Tow<br>Williams bure  | Talbot,Md   |  |  |  |
| 4  | 24   | . PUNERAL DIRECTO   | 3 . 24   |                      | ADDRESS                              | as       | 2Sa. REC D B  |   | ISTRAR'S SIGNATURE                                  |  |  |  |
|  | 1  | Vash  | 1001. In   |                      | 1/tome.                              | 5m       | DATE MA   | R 6 1947 🛭                                  | Charles Jules                                       |  |  |  |

5 may be retained for your files.

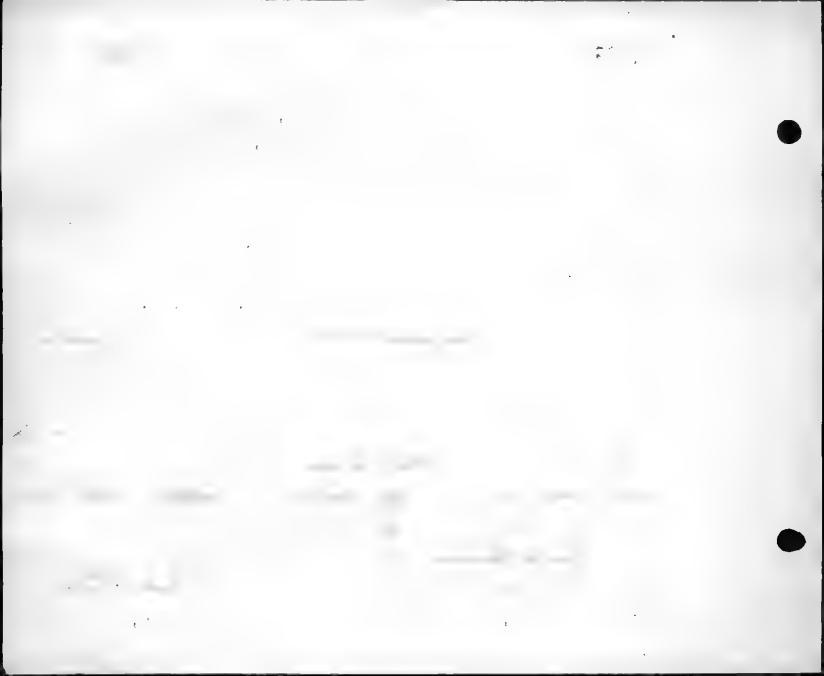
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department af Health or its designated agent, prior to burial, cremation, ar removal, and n any event within 72 naurs after death. the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with farm necessory, please execute the certificate, writing the word "pending" VR A15ME (5 6M 1/66

P.M.3 Page delay s

in pencil in Item 18. Give Poges 1, 2, and 3 to

This certificate should be executed within 24 hours after death

TO DEPUTY MINEAL EXAMINER:

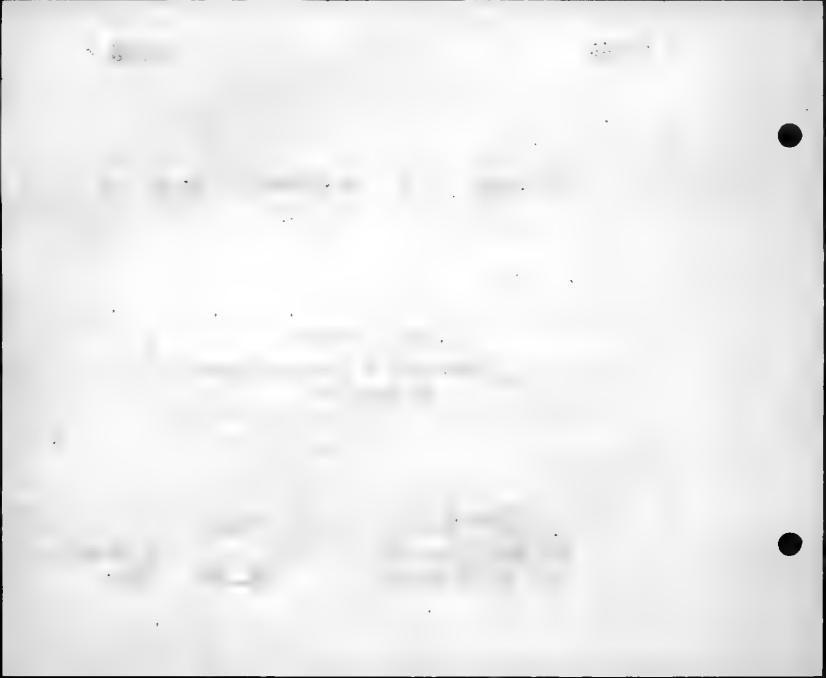


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| Ant  |     | 04239 CERTIFICATI  | F OF DEATH 04238   |  |
|--|-----|--|--|--|
| The second   |     | 1. PLACE OF DEATH o. COUNTY Talbot MARYLAND  | o. STATE Maryland b. COUNTY Tal  | e before odmission) bot                                    |
| by the f<br>Poges<br>ours aft  |     | b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURA, and give nearest town)  | CCITY DR TOWN (If outside corporate limits, write RURAL and give Easton (runal)                                  | 24-1   |
| filled in I<br>papers.<br>thin 72 ha   | 118 | d NAME OF HOSPITAL OR INSTITUTION (H not in hospital, give street oddress)  Memorial Hospital  | d street address<br>RFD #3 Box 36  | e IS RESIDENCE<br>ON A FARM?<br>YES NO                     |
| and coapletely filled in by the remove corbon papers. Poginary event, within 72 haurs  |     | 3. NAME OF DECEASED (Type or print) Gertrole M. J.   | of fran d Date Month 16  | роу <b>Уе</b> аг   |
| and completely<br>remove corbon<br>in only event, wi   | )   | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED   | 8 DATE OF BIRTH  5/15/1901  9 AGE (In years IF UNDER 1  Months Yrs.  | Doys Hours Min.  |
| sicion and please re   | /   | 100. LSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b KIND OF BUSINESS OR TROUGTRY  PELEPhone   | Ontario (anada (1)   | IZEN OF WHAT<br>INTRY?                                     |
| g physicion<br>Then please<br>movol, and i   |     | 13. FATHER'S NAME  George H. Hedderick   | 14. MOTHER'S MAIDEN NAME Annie Bunns   |  |
| signed by the attending physical-transit permit. Then pourial, cremotian, or removol,  |     | (Yes, no, or unknown) (If yes give wor or dotes of service) 212-10-0239 Ju   | idson P. Hoffman, Easton, Md.  | RFD  |
| y the cansit p   | 1   | PART I. DEATH (Enter only one couse per line tog (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY  IMMEDIATE CAUSE (a)   | edema  | ONSET AND DEATH  |
| signed by the<br>burial-transit<br>burial, cremoti   |     | Conditions, if any, which gave (b) Metzytatic  | Kareninos ox   |  |
| hos been see as the been seen as the been see as the been seen as the been seen as the been see as the been seen as the bea |     | storing the underlying couse   Bresch  | THE PROMISE OFFICE CONDITION CHECK IN DARK IN  | I 10 WAS ANTODOV   |
| ficote hos<br>for use a<br>f Health pi   | 1   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO  200. ACCIDENT WAS UNDERLYING  CONTRIBUTING COLUMN COLUM |  | 19. WAS AUTOPSY PERFORMED? YES NO                          |
| certific<br>ched fo<br>pt. of H  |     |  | (Enter nature of injury in Port I or Port II of item 18.)  ACE OF INJURY (Home, form, 20f. (City or town) . (Cou | nty) (Stote)   |
| ter this<br>se detoc<br>tote Dep   |     | Hour o.m. 19 White Not White of work of work   | tory, street, office bldg., etc.)  |  |
| TOR: Af<br>hould be<br>the the S   |     | 21. I certify that (I) (this foshital) attended the deceased fram_saw the deceased glive shall be a supply of the supply of th | at death accurred at \$300 M, from causes and on the   | , that (I) (we) last<br>the date stated abave<br>TE SIGNED |
| DIRECTOR 3 son   | ,   | 22c. PHYSICIAN'S A J. C. J. SACT   | .D. ATTENDING   MED. STAFF   PHYS.   22d. ADDRESS  | Much 67  |
| <b>FUNERAL DIRECTOR:</b> After this certificote hos been director, page 3 should be detoched for use as the should be filed with the Stote Dept. of Health priar to  | I   | NAME (Type) 5-L-75. SE 17171-CL/  230. BURIAL, (REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR   | CREMATORY 23d. LDCATION (City or Town)   | (County) (Stote)   |
| ٦ ۲  | 2   | REDOVAL (Spacify) 3/14/1967 Spring Hil  24. FUNERAL DIRECTOR ADDRESS   | 250 REC'D BY REGISTRAR 25b REGISTRAR'S SI  |  |
| VR A15 (4) 3<br>20 M 1/66  | Ba  | Maries & Nemanuston EASTON   | . Ud MAR 1 5 1967 Scharle  | Just 1   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Leath

Page 4 moy be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 04240 requires that the deoth certificate be executed within 24 hours after deoth 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY Maryland Caroline MARYLAND CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and afve nearest town) Goldsboro filled in b papers. B. IS RESIDENCE ON A FARM? d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not nyhospital, give street address) Rt. 1, Box 84 corben pap NO [ YES 4. DATE NAME OF Middle Lost Month Dny Year completely DECEASED Bey Baby DFATH 19 (Type or print) DATE OF BIRTH AGE (In years IF UNDER YEAR IF UNDER 24 HRS S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED Months lost birthdov's Dovs Hours remov Male WIDOWED DIVORCED pup 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 30a USJAL OCCUPATION (Give kind of work done COUNTRY? INDUSTRY physician t pleose during most of working life, even if retired) Talbet Easten, Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending physis burial-transit permit. Then pl burial, cremation, or removol, Raymend Elliett Jr. Marion E. Hexter 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates at service) None Hospital Recerds INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c), PART I. DEATH WAS CAUSED BY. ONSEL AND DEATH IMMEDIATE CAUSE (o) by the hospitol or attending physicion. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse os the prior to l has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Health | CERTIFICATION ΝO TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year Not While foctory, street, office bldg., etc.) Hour o.m. ot work 21. I certify that (I) (this haspital) attended the deceased from 19 67, to Mari Mar.17 be retained director, page 3 should shauld be filed with the , and that death occurred at OBA M, fram causes and an the date stated abave saw the deceosed alive on... 22b. DATE SIGNED 22o. SIGNATURE MED DIRECTOR PHYS. PHYS 22c. PHYSICIAN'S NAME (Type) 12N, Hanson 23b. DATE THEREOF 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY

VR A15 (4) 20 M 1/66

24.1 FUNERAL DIRECTOR

3-18-67

Union ADDRESS

2So REC'D BY REGISTRAR 196

Goldsbara Maryland 2Sb



| DIVISION OF STATISTICAL RES  | RYLAND STATE DE<br>EARCH AND RECORDS    | S, 301 W. PRESTON   | STREET, BALTIMO  | RE 1, MARYLAND  |
|--|---|---|--|---|
| 04241  |   | E OF DEATH  | $\Omega \Delta$  | 1241  |
| 1. PLACE OF DEATH a. COUNTY TAILST b. CLEY OF TOWN HE WING TO THE WIND           | MARYLAND                                | a. STATE MAG  | ENLAND B. COUN   | DERIV HNNE  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b                 |   | eenstown   | ite RURAL and give nearest town)                          |
| d. NAME OF HOSPITAL OR INSTITUTION (IF not In                                    | hospital, give street address)          | d. STREET ADDRESS   | CC10 31 0 10 10  | e. IS RESIDENCE<br>ON A FARM?                             |
| 3. NAME OF FIRST   | bital<br>Middle                         |   | 4 DATE MONH  | YES NO Day Year   |
| (Type or print) IRUIN  | GORMAN                                  | Ho4+  | 4. DATE Monti  | h 30 1967   |
| 5. SEX 6. COLOR OR RACE 7. MARRIE WILLIAM WIDOWE                                 | D NEVER MARRIED DIVORCED                | 8. DATE OF HIRM<br>8/27/15                                | 9. AGE (in years last birthday) yrs.                           | IF LINDER 1 YEAR HE LINDER 24 HRS.                        |
| Doctor   | KIND OF BUSINESS OR INDUSTRY , COLO INE | 11. BIRTHPLACE (COL                                       | mty & State, or foreign country                                | 12. CITIZEN OF WHAT COUNTRY?                              |
| RALPH L. HOYT  |   | 14. MOTHER'S MAIDE  |  | 9 N   |
| (Yes, no, or unknown) (If yes give war or dates of service)                      | 19-01-1955 RA                           | ALPH L. HOY   | Addres<br>T-Queens   | TOWN MD.  |
| PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)                                | line for (a), (b), and (c).]            | <i>b</i>  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br>3 LLL 2            |
| Conditions, If any, which gave rise to immediate cause (a), stating the DUE TO   | Leennes con                             | rihmin  |  | Egens.  |
| underlying cause last. (c)   | BUTING TO DEATH BUTNOT RELA             | ATED TO THE TERMINAL DI                                   | SEASE CONDITION GIVEN IN                                       | PART 1(a) 19. WAS AUTOPSY                                 |
| PARTII. OTHER SIGNIFICANT CONDITIONS CONTRI                                      |   |   |  | PERFORMED? YES NO   |
|  | DESCRIBE HOW INJURY OCCU                | JRRED. (Enter nature of                                   | injury in Part I or Part II o                                  | if (tem 18.)  |
| 20c. TIME OF INJURY Month, Day, Year 2Dd.<br>Hour a.m. Whl<br>p.m. 19 at we      | e Not While facto                       | CE OF INJURY (Home, far<br>ory, street, office bldg., etc | m, 20f. (City or town)   | (County) (State)  |
| 21. I certify that (I) (this hospital) atter saw the deceased alive on 33 Acres  |   | t death occurred at 7                                     | M, from the causes   | _, 1947, that (I) (we) last and on the date stated above. |
| 220. SIGNATURE   | M.D                                     | D. PHYS D.  | ED. STAFF  | 22b. DATE SIGNED  |
| 22c. PHYSICIAN'S<br>NAME (Type)  | + ARRISIN                               | 22d. ADDRESS  | Mary lover   | - 20 lin 67   |
| NAME (Type) TITURSTON  | 1                                       |   |  |   |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF BURIAL (Specify) APRIL 2               | 23c. NAME OF CEMETERY                   | OR CREMATORY  | 23d. LOCATION (City, to<br>STEVENS V<br>D BY REGISTRAR 25b, R) | own or county) (State)  //LLE MD.  GISTRAR'S SIGNATURE    |

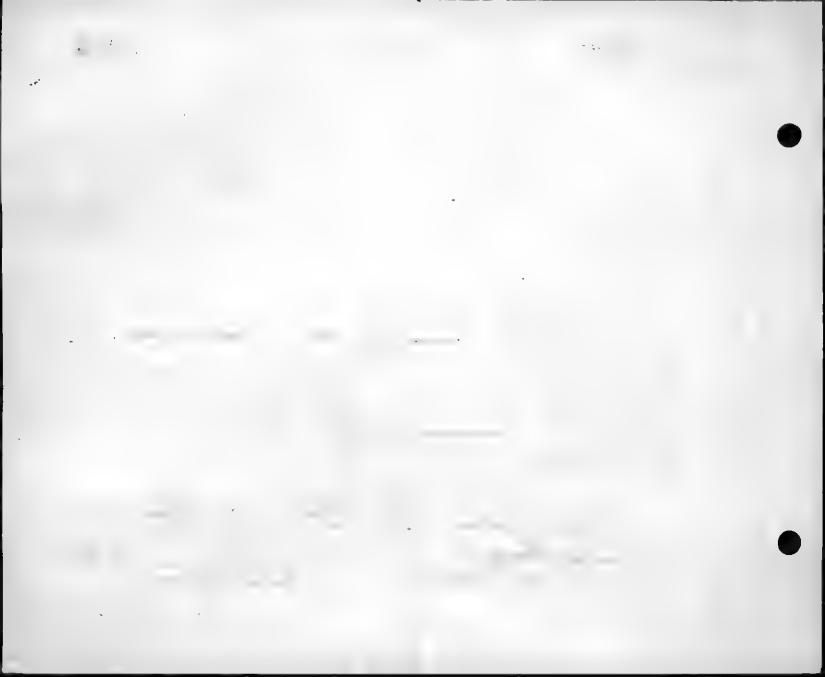


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|  |                 | 04242 CERTIF   | ICATE (             | OF DEATH  |  | 04242                       |  |
|--|-----------------|--|---------------------|---|--|-----------------------------|--|
| in death   |                 | PLACE OF DEATH a. COUNTY  AREA  MARY   | YLAND 2.            | a. STATE MO   | Where deceased lived, if institut<br>b. COUN | ion Residence before        | e admission)<br>C                        |
| within 24 hours ofter death<br>rely filled in by the funeral<br>bon papers Pages Yand<br>within 72 hours offer death   |                 | b. CITY OR TOWN (If autside carparate limits, write RJRAL and give nearest town)   | N 1b c              | CITY OR TOWN (If ou                                 | tside carparate limits, write RUI            | RAL and give neares         | t tawn)                                  |
| lled in I appers in 72 hc  |                 | d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)   | d                   | street address<br>123 Cho                           | ptank Ave.                                   |                             | B IS RESIDENCE<br>ON A FARM?<br>YES NO A |
| withir files of the files of th |                 | NAME OF First Middle DECEASED (Type or print) The Clarene Secial o   | Inster              | Last  | 4. DATE Mont<br>OF<br>DEATH                  | 3 11                        | 1967                                     |
| controve convergence convergen |                 | SEX  6. COLOR OR RACE  7 MARRIED  WIDOWED  DIVORCEE  | 5 1 / 6             | 5/24/21   | 9 AGE (In years<br>lost birthday)<br>45 yrs. | IF JNDER 1 YEAR Months Days | Hours Min.                               |
| cian and eose re   | dur<br>N        | a JSUAL OCCUPAT ON (Give kind of work dane iring most of working life, even feet red).  atchery worker INDUSTRY chick  | ken                 | Dorches   | & State, or foreign country)  Biter, Md.     | 12 CITIZEN OF<br>COUNTRY?   |  |
| physi<br>physi<br>hen pl   | 13              | Thomas Insley  | 14                  | Virgie A  |  |                             |  |
| death of   | 15<br>(Ye       | (es, no, ar unknown) (If yes give war or dates of service)  YOS  WW11  16 SOCIAL SECURITY NO. 212-12-329   | 17. INFO<br>7 Mrs   | RMANT   | Addre<br>rett Dean In                        |                             | bove)                                    |
| requires that the death certificate be executed within 24 hor physician.  signed by the attending physician and campletely filled in signed through permit. Then please remove carbon papers a burial, cremation, or remavol, and in any event, within 72 h  |                 | 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO  |                     | Ollomo  |  | INT                         | ERVAL BETWEEN<br>SET AND DEATH           |
|  |                 | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)   |                     |   |  |                             |  |
| AN: The low all or attendin to attendin to a tendin to be for use os the Health prior to   | ATION           | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL   | ATED TO THE         | TERMINAL DISEASE CON                                | IDITION GIVEN IN PART 1(a)                   |                             | WAS AUTOPSY<br>PERFORMED?<br>ES NO       |
| 三名 指型 岩  | L CERTIFICATION |  |                     |   |  |                             |  |
| e e e e e e e e e e e e e e e e e e e  | MEDICAL         | p.m. of wark C of wark C   | factory,            | F INJURY (Hame, farm<br>street, affice bldg., etc.) |  | (Caunty)                    | (State)                                  |
| the draw the   |                 | 21. I certify that (I) (Mis hashital) attended the deceased saw the deceased above the deceased as the deceased as the deceased above the deceased as the dece | from<br>ond that di | eath occurred at                                    | 9 to M, from causes                          | and on the dot              |  |
| be re Seed w   |                 | 220 SIGNATURE CONSTRUCTION   | M.D.                | ATTENDING PHYS                                      | MED. STAFF PHYS.                             | 22b. DATE SIGN              | malo by                                  |
| O HOSPITAL OR ATT<br>Page 4 may be retain<br>O FUNERAL DIRECTO<br>director, page 3 sho<br>should be filed with   |                 | 22c. PHYSICIAN'S NAME (Type) E. C. H. Schimile   | dx                  | 22d. ADDRESS  | ylin, 11                                     | Payl                        | and                                      |
| Page<br>O Fun<br>direct  | 230             |  |                     | norial Pa   |  | wn) 🗸 (County<br>Tlabot     |  |
| VR A15 (4); ] / 20 M 1/66  | 2               | A FUNERAL DIRECTOR ADDRESS   | E-AS Irm            | MAR .   | 1967 Jed                                     | GISTRA S STOPATUL           | ge.                                      |

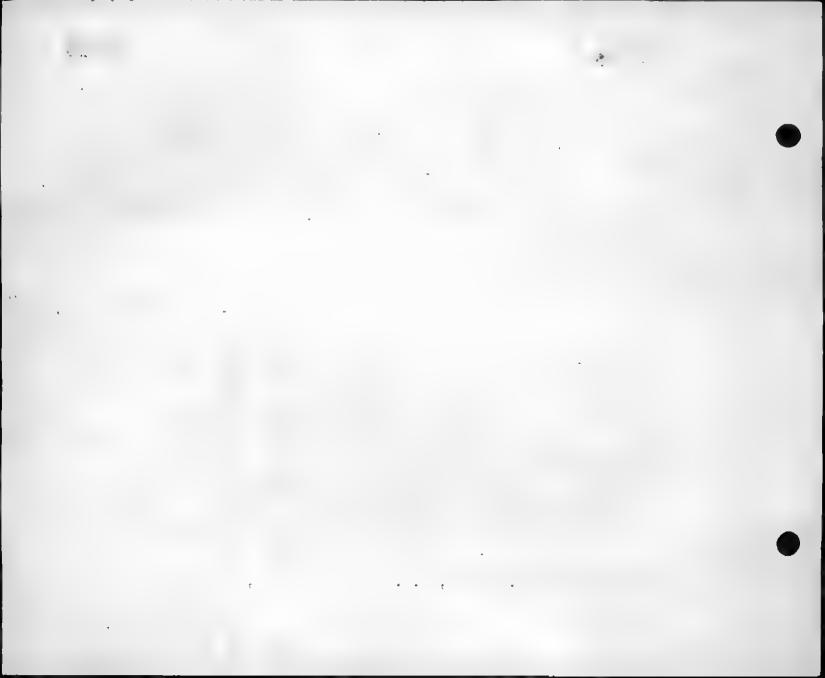


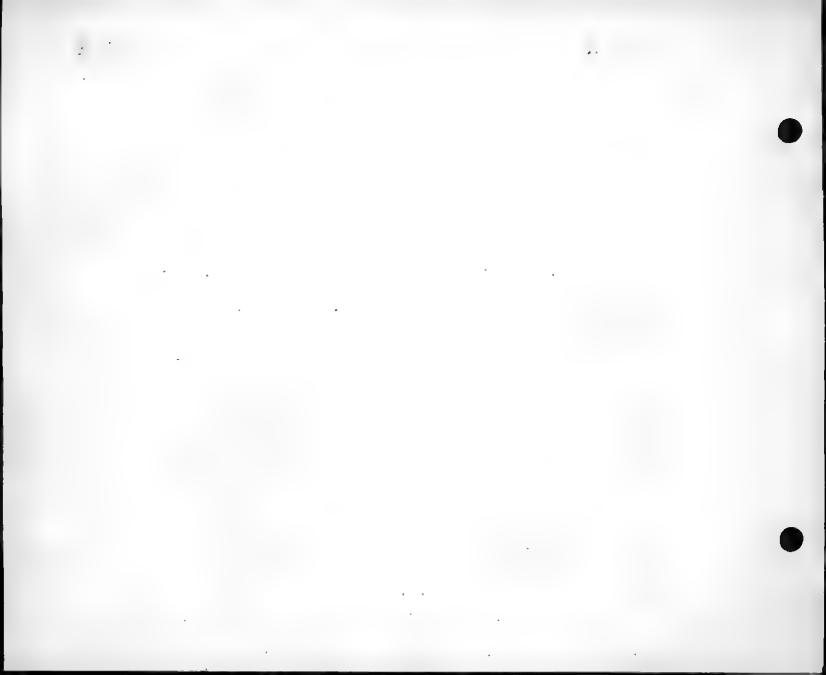
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04243 CERTIFICATE OF DEATH low requires that the death certificate be executed within 24 hours after death puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) filled in by the funeral popers. Pages I and o. COUNTY ofter MARYLAND b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 write RURAL and give nearest town. RASONVILLE IS RESIDENCE ON A FARM? on popers. Within 72 ha d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address YES NO X 3. NAME OF Middle 4. DATE Month Ooy Year First Lost OECEASED (Type or print) 19 6 DEATH 9. AGE (In years SEX 6. COLOR OR RACE NEVER MARRIED lost birthdoy) Months DIVORCED rem) 12 CITIZEN OF WHAT KIND OF BUSINESS OR COUNTRY during most of working life, even if retired) INDISTRY 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME buriol, cremotion, or removal WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes give war or dates of service) RY! BOX 251 GRAS 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY signed by the burial-transit IMMEDIATE CAUSE (o) DUE TO Conditions, if only, which gove rise to immediate cause (a), DUE TO stating the underlying couse by the haspitol ar attending director, page 3 shauld be detoched far use as the shauld be filed with the State Dept. of Health priar to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO, THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) WAS AUTOPS PERFORMED? Carriana certificote 20o. ACCIDENT WAS UNDERLYING [3] 205. DESCRIBE HOW ANJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year TO FUNERAL DIRECTOR: After this factory, street, office bldg., etc.) Hour o.m Not While of work 21. I certify that (I) (this haspital) attended the deceased from 24 flow 30 Mar 19.67, that (1) (we) last be retained 30 lear 19 47, and that death occurred at 42 M, fram causes and an the date stated above. saw the deceased alive on... 22b. DATE SIGNED 22a, SIGNATURE ATTENDING PHYS. 3/ Kear 67 M.D. 22d. ADDRESS Eastan HARRISON NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) BURIAL, CREMATION, ADDRESS BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 EASTON, ING



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH N4244 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH b. county een Anne a STATE o. COUNTY Maryland MARYLAND PHYSICIAN: The low requims that the death certificate be executed within 24 hours after c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) completely filled in by the foods compared to the foods of the foods o b. CITY DR TDWN (if outside corporate firmits, write RURAL and give nearest town) LENGTH OF STAY IN 16 Stevensville ON A FARM? d. STREET ADDRESS INSTITUTION (If not in hospital, give street oddress) □ NO 🕮 XX Year 4. DATE 3. NAME OF Lost DECEASED (Type or print) OF. DEATH AGE (In years 7 MARRIED K 8. DATE OF BIRTH S. SEX 6. COLDR OR RACE NEVER MARRIED lost birthdoy) Months Hours physicion and cor nen please remove noval, and in ony e 1884 □ Sept. 27. DIVORCED WIDDWED White Female 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) 10b KIND OF BUSINESS OR 10o, USJAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) INDUSTRY USA Housewife

13. FATHER'S NAME Maryland 14. MOTHER'S MAIDEN NAME burial, crematíon, or removal, Unknown William Whitby 15. WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service Joseph Kopinke-Stevensville, Md. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c) ) DISET AND DEATH been signed by the s the burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUF TO stating the underlying couse director, page 3 should be detached for use as the should be filed with the Stote Dept. of Health prior to be retained by the hospital or attending 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) has CERTIFICATION TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20f. (City or town) (County) 20e. PLACE OF INJURY (Home, form, 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work 19 , that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 5 M, fram causes and an the date stated above. and that death accurred at 7 saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE STAFF ATTENDING Robert W. Trever M.D. DIRECTOR PHYS. 22d. ADDRESS Easton, Maryland NAME (Type) Robert W. Trever. M.D. 23c. NAME DE CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23b DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify) Stevensvill Stevensville March 9 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR

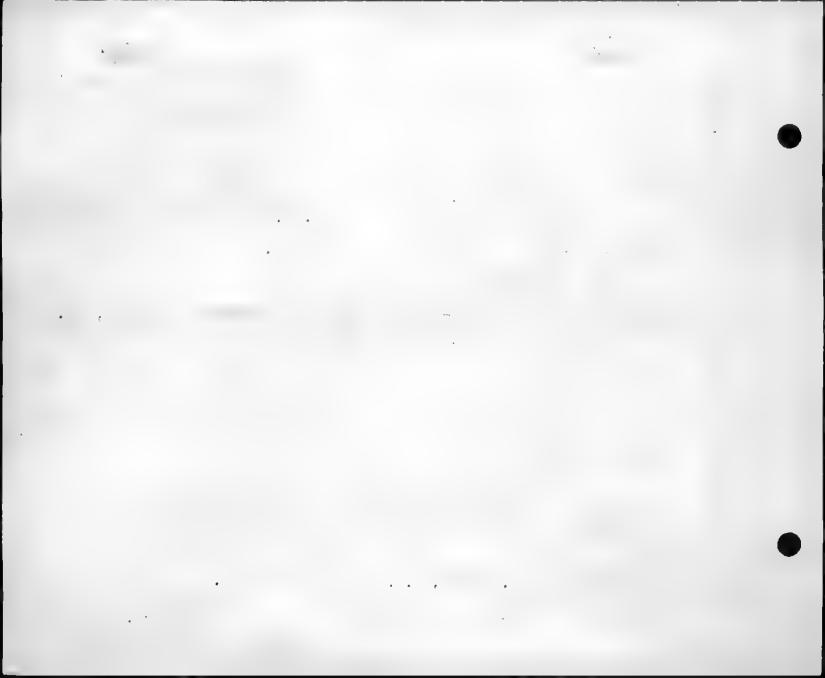




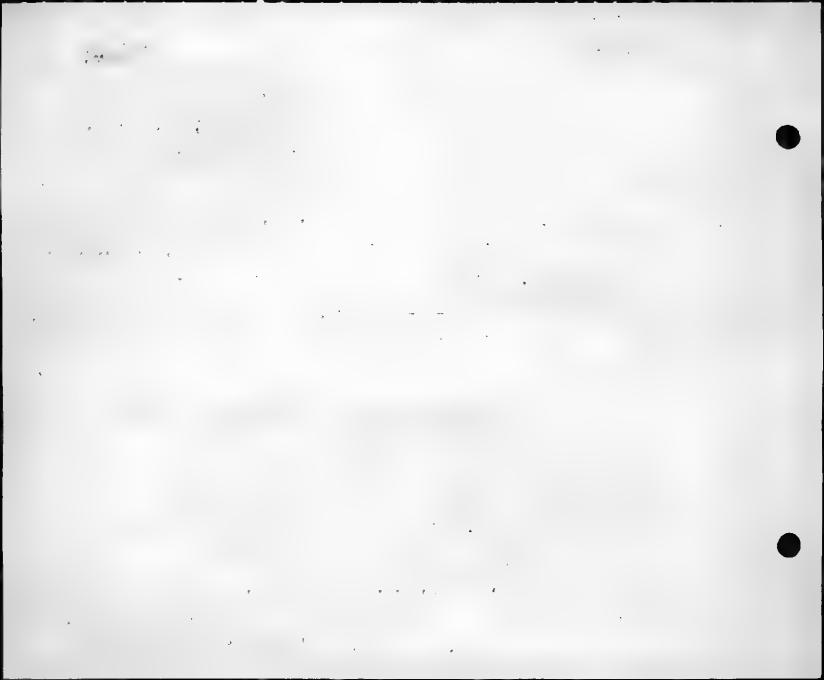
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 04246 requires that the death certificate be executed within 24 hours ofter death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a STATE Maryland a. COUNTY b. COUNTY Careline. MARYLAND c. CITY OR TOWN (If autside carparate i mits, write RURAL and give nearest tawn)

Rural Greensberg signed by the attending physician and completely filled in by the burial-transit permit. Then please remove corban papers. Pages burial, cremation, or removal, and in any eyent, within 72 hours aft b CITY OR TOWN (If autside carparate imits, write RURAL and give\_nearest town) C LENGTH OF STAY IN 16 2 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS MERCEV. al YES NO None 3 NAME OF First Middle Last 4. DATE Manth Day Year DECEASED 3 22 (Type or print) DEATH 19 9 AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS SEX B. DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED + **NEVER MARRIED** last birthday) Male WIDOWED White DIVORCED an.24.1883 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10o USUA, OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of warking fe, even if refired) COUNTRY? INDUSTRY Farming Penna. TISA 13 FATHER S NAME
Samuel 14. MOTHER S MA DEN NAME McCreary No Record 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war ar dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address Mary Mc Creary Greensberg. 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), PART 1. DEATH WAS CAUSED BY NJERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) be retained by the hospital or attending physicion. DUE TO Canditians, if any, which gave rise to immediate couse (o). DUE TO stating the underlying cause as the prior to l has been last WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) etoched for use of Dept. of Heolth p CERTIFICATION NO TO FUNERAL DIRECTOR: After this certificate 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Haur a.m. at wark at wark \_, 19\_\_\_\_, that (I) (we) last \_\_\_\_\_, ta\_\_ 21. I certify that (I) (this hospital) attended the deceased from director, page 3 should should be filed with the 19\_\_\_\_, and that death accurred at // 30\_M, fram causes and an the date stated above sow the deceased alive on\_\_\_\_\_ 22b. DATE SIGNED 22g. SIGNATURE STAFF PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Page 4 may Easton, Md. Robert W. Trever. M.D. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23b. DATE THEREOF 23d LOCATION (City or Town) (County) BENOVA (SOTIA) Greensbore Greensbore. Maryland 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR **ADDRESS** 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH



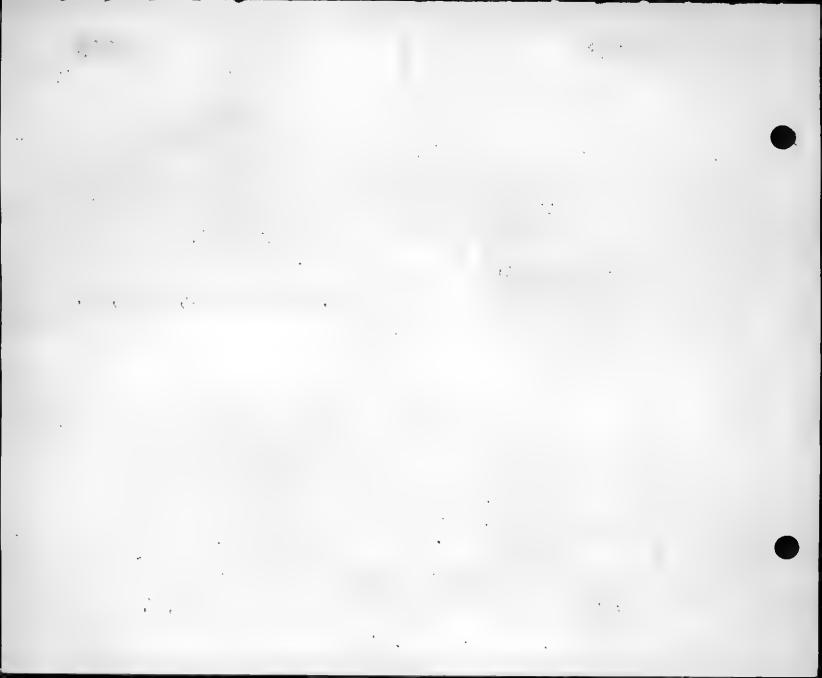
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after the page.

|             | MARYLAND STATE DEPARTMENT OF HEALTH                      |                              |
|-------------|--|------------------------------|
| DIVISION OF | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, | <b>BALTIMORE 1, MARYLAND</b> |
| FOFO        | CEDTIFICATE OF DEATH                                     | 04040                        |

| ì | _             | 04248 CERTIFICAT   | E OF DEATH 042   | 19                                  |
|---|---------------|--|--|-------------------------------------|
|   | 1.            | PLACE OF DEATH a. COUNTY   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Re                       |                                     |
|   |               | (Prido) MARYLAND   |  | roline                              |
| 1 |               | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   | c. CITY OR TOWN (If outside corporate limits, write RURAL                          | and give nearest town)              |
|   |               | d. NAME OF HOSPITAL OR INSTITUTION (if not in pospital, give street address)   | Denton d. STREET ADDRESS   | e. IS RESIDENCE                     |
| 7 |               | Memorial Pospital  | Fisher Road  | ON A FARM? YES NO 1                 |
| ľ | 3.            | NAME OF First Windle   | Last 4. DATE Month   | Day Year                            |
| ١ |               | (Type or print) JAMES DRALFORD   | MORRIS DEATH 3 2   | 8 1967                              |
| ١ | 5.            | , markited _ Rever markited  | 8. DATE OF BIRTH 9. AGE (In years IFUNDER last birthday) Months                    | Byys Hours Min.                     |
| ŀ | 100           | male white WIDOWED DIVORCED  | 3/0/190/ yrs.  | 20                                  |
| ١ | dur           | . USUAL OCCUPATION (Give kind of work done INDUSTRY  10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country) 12. CI                         | TIZEN OF WHAT<br>UNTRY?             |
|   | 13.           | FATHER'S NAME  | 14. MOTHER'S MAIOEN NAME   |                                     |
| ١ |               | Bradford Morris  | Peggy Anne Nyce  |                                     |
| ľ | 15.<br>(Ye    | a man and a sub-like and the sub-like an | INFORMANT Address  | As Les                              |
|   |               | /1,  | rs. Bradford Morris, Denton,   | MbL.                                |
| - |               | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  | INTERVAL BETWEEN<br>ONSET AND DEATH |
| ۱ |               | PART I. DEATH WAS CAUSED BY: Creek tolde tir   |  |                                     |
| 1 |               | DUE TO   |  |                                     |
|   |               | Conditions, if any, which gave rise to immediate (b)   |  |                                     |
|   |               | cause (a), stating the DUE TO underlying cause last.   |  |                                     |
|   | NOI           | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA   | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)                          | 19. WAS AUTOPSY<br>PERFORMED?       |
|   | CA            |  |  | YES NO                              |
|   | CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING TO AUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | JRRED. (Enter nature of injury in Part I or Part II of Item 18.                    |                                     |
|   | - 1           |  |  | (01-4-3                             |
|   | MEDICAL       |  | CE OF INJURY (Home, farm, 20f. (City or town) (Courry, street, office bldg., etc.) | nty) (State)                        |
|   | ME            | p.m. 19   at work     at work  |  |                                     |
|   |               | 21. I certify that (I) (this hospital) alterded the deceased from saw the deceased alive on that   |  | , that (I) (we) last                |
|   |               | 22a. SIGNATURE   |  | TE SIGNED                           |
|   |               | Elliper  |  | Nast 161                            |
| / |               | 22c. PHYSICIAN'S EC-H. Setiment  | 1220. ADDRESS FRANCISCO, Mary large  | 1.                                  |
|   | 23a           | Burial (Specify) 3/30/1967 Spring Hill   | OR CREMATORY 23d, LOCATION (CITY, town or cou                                      | nty) (State)                        |
|   | 24            | FUNERAL DIRECTOR ADDRESS   | 25a. REC'O BY REGISTRAR 25b. REGISTRAR'S   | 70                                  |
|   | 1/1           | annice neuram & Son Caston   | 20. MAR 30 1967   June 18  | Judge.                              |

VR AI5 (4) 20M 1/65

7-12

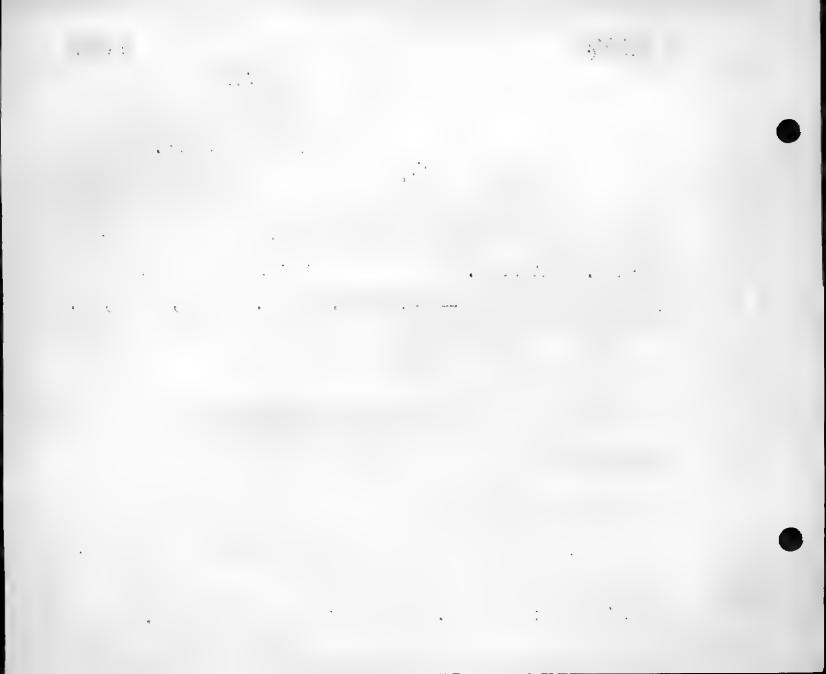


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201

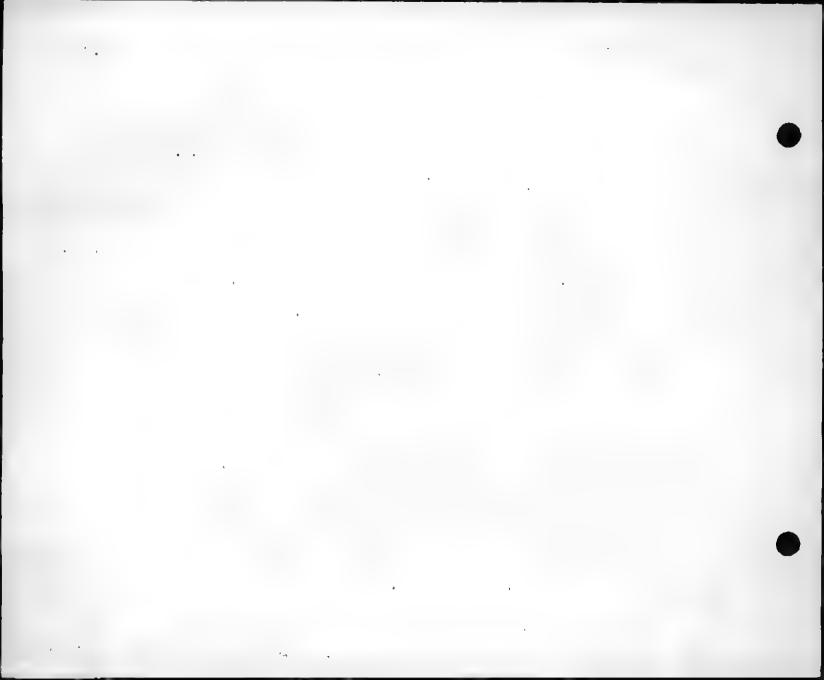
|  |                    | DIVISION OF STATISTIC  | AL RESEARCH AND RECORDS, SOI               | W. I RESTOR STREET, DALITHON  | IL, MARILAND ZIZOI  |
|--|--------------------|--|--|---|---|
| ei .   |                    | 04249  | CERTIFICATE                                |   | 04250   |
| en déot  |                    | O. COUNTY TAIDOT   | MARYLAND                                   | 2 USUAL RESIDENCE (Where deceased liv<br>a. STATE Maryland            | b. COUNTY Talbot  |
|  |                    | b. CITY OR TOWN (If outside carporate limits, write RURAL and give necrest town)                           | c LENGTH OF STAY IN 16                     | c. CITY OR TOWN (If outside corporate lim                             | nts, write RURAL and give nearest town)                             |
| 72 hoi   |                    | d. NAME OF HOSPITAL OR INSTITUTION (If not i   | n haspital, give street address)           | d. STREET ADDRESS  114 Trea Avon                                      | e. IS RESIDENCE   |
| ithin .  | 3                  | MEMORIAL<br>NAME OF FIRST  | HOSPITH L                                  | Last 4. DATE  | Manth Day Year  |
| int, w   |                    | (1) be at bound  | an H. me                                   | ullikin OF DEATH  | 3 9 1967  |
| buriol, cremation, or removol, and in Bay, event, within 72 ho | 7                  | male white   | MARRIED NEVER MARRIED 5 WIDOWED DIVORCED 5 | 4/16/16 5   | purthday) Months Days Hours Min.                                    |
|  | 10a<br><b>d</b> บท | JSUAL OCCUPATION (Give kind of work done ing most of working life, even if retired)                        | 106 KIND OF BUSINESS OR<br>INDUSTRY        | 11 BIRTHPLACE (County & State, or foreign Talbot Maryland             | - COMMIDV2  |
|  | 13.                | James T. Mullikin,   | Ino  | 14. MOTHER'S MAIDEN NAME<br>Lillian Scars L                           | arrimore  |
|  | 15<br>{Ye          | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>is, na, ar unknown) (If yes give wor or dotes of s              | 16, SOCIAL SECURITY NO. 17 I               | NFORMANT<br>S. Edgar M. Mullik  | in, Easton, Md.   |
|  |                    | 18. CAUSE OF DEATH (Enter only one cause<br>PART I. DEATH WAS CAUSED BY:                                   | per line for (a), by and (c).)             | al anderster  | INTERVAL BETWEEN ONSET AND DEATH                                    |
| N, CI 611  |                    | IMMEDIATE CAUSE (a) DUE TO   | Carken                                     | a-liberian  |   |
|  |                    | Conditions, if any, which gave (b) rise to immediate cause (o), stating the underlying cause               |  | o ecception .   |   |
|  |                    | PART II. OTHER SIGNIFICANT CONDITIONS CON  |  | HE TERMINAL DISEASE CONDITION GIVEN IN                                | PART 1(a) 19. WAS AUTOPSY   |
| /  | CATION             | PRE II. OTTER SIGNIFICANT CONDITIONS CON   | BOT NOT RESIDENT                           | THE TEMPHINE PROPERTY CONTINUES OF THE TEMPHINE                       | YES PROPRIED?   |
|  | CERTIFICATION      | 20g. ACCIDENT WAS UNDERLYING ☐<br>OR CONTRIBUTING ☐ CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 205. DESCRIBE HOW INJURY OCCURRED.         | Enter nature of injury in Part f or Part II o                         | f item 18.)   |
|  | MEDICAL            | 20c. TIME OF INJURY Manth, Doy, Year<br>Haur a.m.<br>p.m. 19   |  | E OF INJURY (Hame, farm, 20f (Cit<br>ary, street, affice bldg., etc.) | y or tawn) (Caunty) (State)   |
|  |                    |  | tal) attended the deceased from            | death occurred at 10 3 M fr   | , 19, that (I) (we) last<br>am causes and on the date stated above. |
| ,  |                    | 22a. SIGNATURE   | 1  | ATTENDING — MED —   | STAFF PHYS. DATE SIGNED 10 March 67                                 |
| ,  |                    | 22c. PHYSICIAN'S<br>NAME (Type)  | 4 Co hinest                                | D. PHYS DIRECTOR L  | March   |
| 1  | 23 c               | BURIAL CREMATION, 23b DATE THERE   |  |   | ON (City ar Tawn) (Caunty) (State)                                  |
| Y P  | 2,6                |  | 967 Voodlaun Memo                          | rial Park Casto   |   |
| 171  | 1                  | Maurice E. Neurs   | , , ,                                      | MAK 1 4 196   | 7 25by Heistran's signmure  |

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or ottending physician.



Item 18 Film 388 5-8-67 amaryland State DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

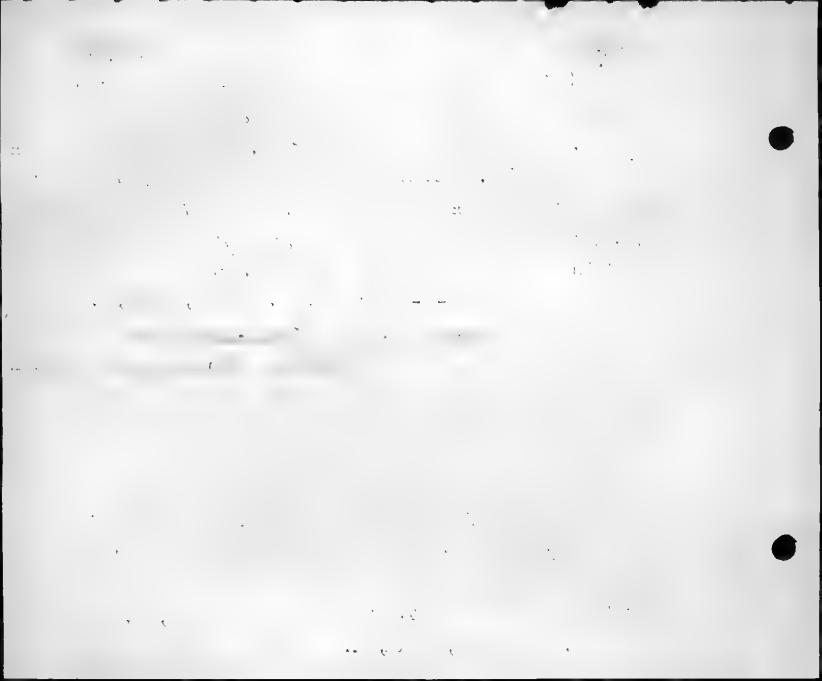
Them #4 Film #2227 3/30/67 pg... CERTIFICATE OF 04251 'DEĂTH requires that the death certificate be executed within 24 llours after lleath. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) filled in by the funerg a. COUNTY\_ a. STATE b. COUNTY Poges\_L MARYLAND c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) EASTON e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS YES carbon NAME OF 4 DATE Month Day Year Last **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and comp<del>letely, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon</del> DECEASED 0F March 67 19 Type or print) DEATH 9. AGF (In years IF UNDER 1 6 COLOR OR RACE DATE OF BIRTH last birthday) DIVORCED WIDOWED 12. CITIZEN OF WHAT 10a JSUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) ng most of working life, even if fet red) INDUSTRY COUNTRY 3 FATHER S NAME MOTHER'S MAIDEN NAME or removal, 17. INFORMAN (If yes give war ar dates at service (Yes, na, or unknown) burial, cremation, IB. CAUSE OF DEATH (Enter only one cause pel PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) be retained by the hospitol or attending physicion. DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse ed for use as the of Health prior to last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO NO X CERTIFICAT 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (State) (City or town) (County) Haur a.m foctory, street, affice bldg., etc.) Not While at wark at wark director, page 3 should should be filed with the 10 M, from causes and on the date stated above. saw the deceased alive on , and that death occurred at 22a. SIGNATURE 22b. DATE SIGNED STAFF M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c PHYSICIAN'S Poge 4 may R. Lane Wroth, M. D. St. Michaels. Md. 21663 23a BURIAL, CREMATION, 23b. DATE THEREO 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or (State) (County) UNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 04252 PLACE OF DEATH death. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY Talbox after Talbox MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ve carbon papers. Pages event, within 72 hours aft c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b hours aston Ξ. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled e. IS RESIDENCE ON A FARM? 113 N. Hanson Street 113 N. Hanson Street NO 3d executed within completely NAME DE DATE Middle Year DECEASED Bethesda W. Robinson 19 67 (Type or print) DEATH 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. physician and con please remove 7. MARRIED NEVER MARRIED birthday) Months Days WIDOWEDE DIVORCED 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? ousework 13. FATHER'S NAME Adoni Ross Martha A. Cooper 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | (If yes give war or dates of service) 16. SOCIAL SECURITY NO. | 17. INFORMANT the attent t permit. Walter W aston. Ad. transit perm cremation, 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN n signed by burial-transit burial, crema ONSET AND DEATH PART I, DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) been the built to bu gave rise to immediate DUE TO cause (a), stating the prior t underlying cause last. has 38 (C) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 119. for use Health use certificate PERFORMED? YES [ NO T PHYSICIAN: 20a, ACCIDENT WAS UNDERLYING [ After this certifing the detached for State Dept. of H DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part | or Part | of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **EDICAL** 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) Hour a.m. factory, street, office bldg., etc.) After Not While ATTENDING 19 at work at work p.m. retained P 21. I certify that (i) (this hospital) attended the deceased from shoul DIRECTOR: Ac.M. from the causes and on the date stated above. 3 sho saw the deceased alive on and that death occurred at. 22a. SIGNATURE page M.D. DIRECTOR тау director, po O HOSPITAL FUNERAL ADDRESS 22c. PHYSICIAN'S 22d. NAME (Type) 23a. BURIAL, CREMATION, REMOVAL (Specify) NAME OF CEMETERY OR CREMATORY 23b. 23c. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR REGISTRAR'S SIGNATURE REC'D BY REGISTRAR VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH



## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| M  |           |               | 04253  | CERTIFICAT                                     | E OF DEATH                        | 04   | 1255                                       |
|--|-----------|---------------|--|--|-----------------------------------|--|--|
| fune of land   |           |               | COUNTY Talket  | - ( MARYLAND                                   | II a STATE AA                     | (Where deceased lived, if institute b. COU     | non-Residence before odmission)  NTV albot |
| by the Pages   |           |               | o CITY OR TOWN (If outside corporate write RURAL and give nearest town)                                    | 50N 32 days                                    |                                   | outside corporate limits, write RU<br>Lichaels | KAL one give nearest rown)                 |
| within 24 hours or experience of the box papers Page within 72 hours or within 72 hours o | 78        |               | ! NAME OF HOSPITAL OR INSTITUTION (  | If not in hospital, give street address) *     | d. STREET ADDRESS                 |  | P IS RESIDENCE<br>ON A FARM?<br>YES NO X   |
| cecuted within 24 has completely fulled in nove teachers appers by event, within 72 h  |           | L             | NAME OF DECEASED Type or print)  | George Joseph                                  | Shea                              | 4. DATE Mon<br>OF<br>DEATH 3                   | 16 1967                                    |
| e executed and complet remove term only event,   |           | S.            | male white   | 7 MARKIED MEVER MARRIED DIVORCED DIVORCED      | 8 DATE OF BIRTH 5/12/1878         |  | Months Doys Hours Min.                     |
| ate be<br>icion an<br>leose re<br>ond in a   |           | dur           | USUAL OCCUPATION (Give kind of work of<br>ng nost of york ng life, even if retired)<br>Danken              | one 10b KIND OF BUSINESS OR INDUSTRY           | Brooklyn                          |  | 12. CITIZEN OF WHAT                        |
| that the deoth certificate be executed within 24 hours ofter on.  by the attending physicion and completery filled in by the furnansit permit. Then please remove carbon papers Pages 1 cremotion, or removal, and in any event, within 72 hours after   |           |               | Thomas Shea  |  | Mary E.                           | McHugh   |  |
| affendin<br>permit.<br>on, or re   |           | 15.<br>(Y∈    | WAS DECEASED EVER IN U.S. ARMED FORE s, no, or unknown) (If yes give wor or do                             | tes of service) 086-10-2677 A                  | INFORMANT<br>Mrs. George          | J. Shea, St.                                   | Michaels, Md.                              |
| s that the daion.  d by the attictions transit performation, cremotion,  |           |               | IMMEDIATE CA   |  | scular Oc                         | clusion Mu                                     | INTERVAL BETWEEN ONST AND DEATH            |
| physicio<br>physicio<br>signed k<br>buriof-tr<br>buriof, c   |           |               | Conditions, if any, which gave   |  | eroscler                          | osis.  | Jeans.                                     |
| law re<br>inding<br>been s<br>is the t   |           |               | lost.  | DUE TO  (c)                                    | THE TERMINAL DIFFACE C            | CURITION CHIEN IN DART 1/-1                    | 19 WAS AUTOPSY                             |
| AN: The all or otte icate hos for use o  | 1,<br>195 | CERTIFICATION |  | NS CONTRIBUTING TO DEATH BUT NOT RELATED TO    |                                   |  | PERFORMED? YES NO                          |
| YSICIA<br>nospital<br>certifica<br>thed fo<br>pt. of H   |           |               | 200. ACCIDENT WAS UNDERLYING ☐<br>OR CONTRIBUTING ☐ CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 205 DESCRIBE HOW INJURY OCCURRED               | LACE OF INJURY (Home, fo          |  | (County) (Stote)                           |
| ING PH<br>by the I<br>ter this<br>se deta<br>tote De   |           | MEDICAL       | 20c. TIME OF INJURY Month, Doy, Ye Hour o.m. p.m.  | 19 While Not While of twork of work            | actory, street, office bldg., et  | (c) 1 2 PA                                     |  |
| OR ATTEND be retained by SIRECTOR: Af je 3 should be ed with the S   |           |               | 21. I certify that (1) (this saw the deceased alive at 220. SIGNATURE                                      | haspital) attended the deceased fram.          | at death accurred o               | at // 25 p.M., from kauses                     | and an the date stated above               |
|  |           |               | 22c PHYSICIAN'S  | ///  | W.D. ATTENDING PHYS. 22d. ADDRESS | MED STAFF DIRECTOR PHYS.                       | 3/17/67                                    |
| SPIT/<br>4 mo<br>IERA<br>or, p   | 1         | 230           | NAME (Type) Se RELEASE.  BURIAL, CREMATION, 23b. DAT   | ECEL J' JR ,  THEREOF 235, NAME OF CEMETERY OF | R CREMATORY                       | PASTON (City or I                              | own) (County) (Stote)                      |
| . –  | R         | 24            | REMOVAL (Specify) 3/20 FUNERAL DIRECTOR  | 0/1967 Woodlaun M                              | emorial Pan                       | C'D BY REGISTRAR 2Sb B                         | COSTRAR'S SIGNATURE                        |
| VR A15 (4)   | 141       | 6             | Harrison E Abre  | MANUEL BASTON                                  | Ind . MA                          | R 2 1 1967 🔏                                   |  |



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|         |                       | 04254  | CERTIFICATE   | OF DEATH  |   | 4258  |
|---------|-----------------------|--|---|---|---|---|
|         |                       | PLACE OF DEATH TALBOT  | MARYLAND  | 2. USUAL RESIDENCE (WI<br>o. STATE                        | here deceosed lived, if institution<br>b. COUNT |   |
|         | Ł                     | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                   | DOA 16  | c, CITY OR TOWN (If outs                                  | side corporote limits, write RURA               | L and give nearest town)  |
| 19      | C                     | d. NAME OF HOSPITAL OR INSTITUTION (If not in he   | pospitol, give street oddress)  HOSPITAL-                           | 52/Da   | ver Rol.  | e IS RESIDENCE<br>ON A FARM?<br>YES NO  |
|         | (                     | NAME OF PIRST PROCESSED (Type or pnnt)   | Middle<br>HARRIS S  | HCKLEY  | 4. DATE Month OF DEATH 3                        | Doy Year<br>2- 1967   |
|         |                       | male orl wil   | ARRIED NEVER MARRIED 8  DOWED DIVORCED                              | F/11/8F   | lost birthdoy)                                  | IF UNDER 1 YEAR   IF UNDER 24 HRS<br>Months Doys Hours Min                        |
|         | don                   | JSJAL OCCUPATION (Give kind of work done ing most of working life, even if retired)                | 10b KIND OF BUSINESS OR INDUSTRY                                    | Harringi  | State, or foreign country)                      | 12. CITIZEN OF WHAT COUNTRYS  |
|         |                       | Durull Sho   | chley   | 14. MOTHER'S MAJOEN NO                                    | el Callin                                       | is  |
|         | (Ye                   | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>is, no, or unknown) (If yes give wor or dotes of servin |   | era Blac  | Accell- 5                                       | 2/ Women Rd.  |
|         |                       | 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)       | Time for (o), (b), and (c)) Myocarde                                | al defe   | acting  | INTERVAL BETWEEN  |
|         |                       | Conditions, it any, which gave (b)   | Congest   | we to   | rail tail                                       | re MONEHS   |
|         |                       | stoting the underlying couse (c)   | Generalizes   | arten   | osclaros  | year WAS AUTOPSY  |
| Je<br>K | ICATION               | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB  | me Card   | errase  | ulan Kr   | PERFORMED? YES NO   |
|         | MEDICAL CERTIFICATION | 200 ACCIDENT WAS STORLYING  OR CONTRIBUTING CALUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 205. DESCRIBE HOW INJURY OCCURRED. ( 206. INJURY OCCURRED 20e. PLAC |   | ·   | (County) (Stote)  |
|         | MEDIC                 | 20c. TIME OF INJURY Month, Doy, Year<br>Hour a.m.<br>p.m. 19                                       | While Not While focts   | E OF INJURY (Home, form, ary, street, office bldg., etc.) |   |   |
|         |                       | 21. I certify that (1) (this haspital) saw the deceased alive an 220. SIGNATURE                    | ottended the deceased fram  | death accurred at_  | M, from causes a                                | , 1962, that (10) (we) last<br>nd an the date stated abave.<br>I 22b. DATE SIGNED |
|         |                       | 22c. PHYSICIAN'S   | Figson M.D  |   | MED STAFF DIRECTOR PHYS.                        | MAR 3-67  |
| 1       | 230                   | NAME (Type) R. Tyson  BURIAL CREMATION. 1 23b. DAJE THEREOF  | 23c. NAME OF CEMETERY OR (  |   | Maryland 23d to CATION (City or Town            | 3/3/67<br>(Stote)   |
|         | 1                     | SEMOVAL ISPECTIVE 3/6/67   | Polling Shee  | w Com.  | West Che  | STRAR'S SIGNATURE   |
|         | d                     | Ocaliel-France   | 1/1 600   | DATE  | 1961 July                                       | will Judge  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth. Poge 4 may be retained by the hospital or ottending physicion. TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after dear VR A15 (4) 20 M 1/66



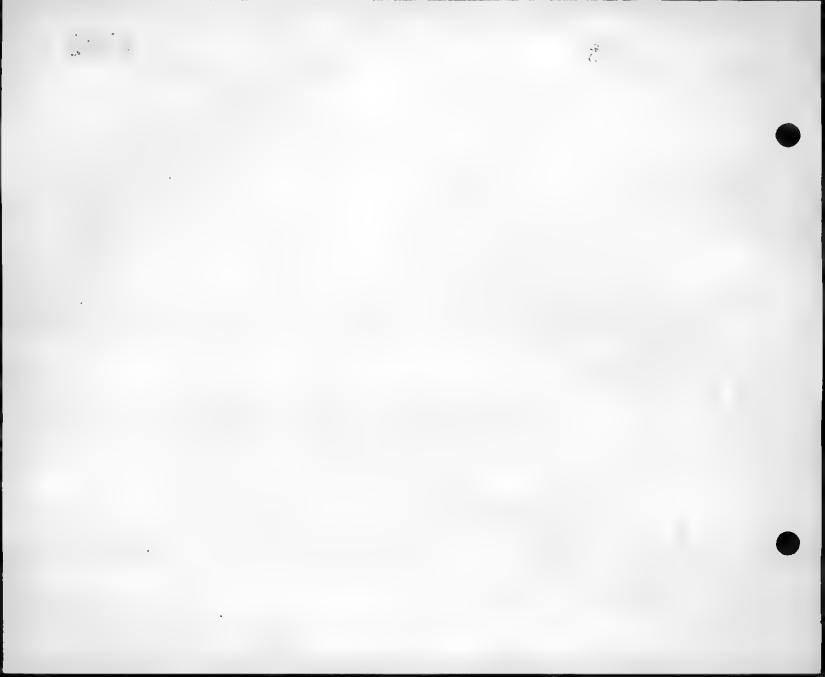
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|               | 04255   | CEKTIFICATE OF DEATH   | O RAU 8  |
|---------------|---|--|--|
|               | PLACE OF DEATH  |  | ved, if institution Residence before admission)  |
| 4             | O COUNTY / H 1 b o T  | MARYLAND MARULAND  | b COUNTY ALBOT   |
|               | b CITY OR TOWN (If outside corporate limits,  | c LENGTH OF STAY IN 1b C CITY OR TOWN (If outside corporate in                 | mits, write RURAL and give nearest town)   |
|               | write RURAL and give recorest town  | & hR. EASTON   |  |
| -             | MAME OF HOSPITAL OR INSTITUTION (If not   |  | e. IS RESIDENCE<br>ON A FAR M?   |
|               | Memorial +  | 05 pital 214 S. HANSO  | N YES NO N   |
|               | NAME OF First   | Middle Los! 4 DATE   | Month Day Year   |
| -             | OECEASED (Type or print) Estelle  | CAVERTON DINITH DEATH  | 3 20 1961  |
| 4             | SEX 6 COLOR OR RACE 7   | MENTALED INCHASED  | GE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. st birthday) Months Doys Hours Min   |
|               | F W   | WIDOWED DIVORCED JULY 22, 1895   | 71 415 7 26  |
| 00            | USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired)           | 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign INDUSTRY      | country) 12 CIT-ZEN OF WHAT COUNTRY?   |
| F             | PRACTICAL NURSE   | IKETIRED TOLKOT CO. WAR  | BULAND U.S.A.  |
| 13            | FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |  |
| T             | HOMAS E. LEAU   | ERTON SALWE R. MULL  |  |
| 15<br>(Ye     | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>is, no, or unknown) (If yes give wor or dates of s | ervice) 16 SOCIAL SECURITY NO 17. INFORMANT                                    | Address  |
| _             | 1 = 23  | 1314-134-10044 LEWIS 20111H  | EASTON, MP.  |
|               | 1B. CAUSE OF DEATH (Enter only one couse<br>PART 1. DEATH WAS CAUSED BY:                      | per lines for (a), (b) and (c))  | INTERVAL BETWEEN ONSET AND DEATH   |
|               | IMMEDIATE CAUSE (o)   |  |  |
|               | OUE TO Conditions, if ony, which gove ) (b)   |  |  |
|               | rise to immediate cause (o),  |  |  |
|               | stating the underlying couse (c)  |  |  |
| _             |   | TRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN II  | PART 1(o) 19 WAS AUTOPSY   |
| 5             | _   |  | PERFORMED? YES NO  |
| CERTIFICATION | 200 ACCIDENT WAS UNDERLYING   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II | of item 1B.)   |
| ĕ             | OR CONTRIBUTING (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                          |  |  |
| MEDICAL       | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.   | SARLEL MARKET Sections comes office high rate \                                | ty or town) (County) (State)   |
| ğ             | p.m. 19   | ot work U ot work U  |  |
|               |   | fall) gttendød the deceased fram, 19 ta_                                       | , 19, that (I) (we) la   |
|               | saw the deceased glive an 🚄   | M, f   | ram causes and an the date stated abov   |
|               | 220. SIGNATURE  | ATTENDING MED.   | STAFF PHYS. X 22b. DATE SIGNED   |
|               | 22c. PHYSICIAN'S / /\   | M.D PHYS DIRECTOR DIRECTOR 22d. MODRESS  | ALL THE STATE OF T |
|               | NAME (Type)   | gelymall Enter, 11   | IA   |
| 230           | BURIAD CREMATION, 236 DATE THERE  | EOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCAT                               | ON (City or Town) (County) (Stote)   |
|               | REMOVAL (Specify) MAR. 23.  |  | ON TALBOT MT.  |
| 24            | FUNERACCOURTEROR  | ADDRESS 250, REC'D BY REGISTRAR  | 2Sb, 266ISTRAR'S SIGNATURE   |
|               | 1111-1-113 7 1- 189   | (/ // /// // MARY 3 4 14L  | A CACALLINA MARKET   |

to Hospital or attending PHYSICIAN: The low requires that the death certificate be executed within 24 hours after dea Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 20 M 1/66

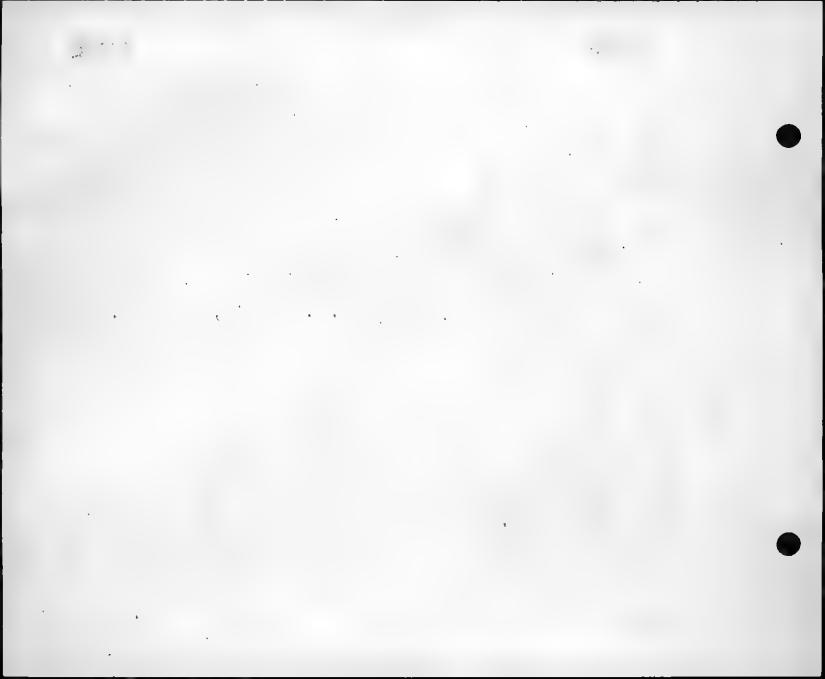


## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04256 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY MARYLAND requires that the demth certificate be executed within 24 hours after physician and campletely filled in by the f b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 15 (If ourside corporate limits, write RURAL and give nearest town) write RURAL and give\_nearest town) IS RESIDENCE ON A FARM? d, NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS signed by the attending physician and ca<u>mpletel</u>y filled ir burial-tronsit permit. Then please remove carbon papers buriol, cremotion, or removal, ond in ony event, within 72 remores NO V 3 NAME OF Middle DATE Month Doy Fiest Year OF DECEASED ARCH 196 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX DATE OF BIRTH AGE (In years COLOR OR RACE 7. MARRIED **NEVER MARRIED** lost birthdoy) Days WIDOWED DIVORCED 106 KIND OF BUSINESS OR 12. CITIZEN OF WHAT The JSUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State or foreign country) COUNTRY during most of working the, even if refired) Huto Supply Talbox Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME Frank Smith W**il**hemina Blann WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (a), INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSEIF AND DEATH IMMEDIATE CAUSE (o) by the hospital or attending physicion. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate hos been be detached for use as the State Dept. of Health prior to last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO. ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING [ 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour om. Not While at work at work 19 47\_to 21. I certify that (1) (this haspital) attended the deceased from 12 Man Page 4 may be retoined director, page 3 should should be filed with the and that death accurred at 985 M, fram causes and on the date stated above. saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF Mun DIRECTOR M.D. PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. (County) (Stote) herry Hill

VR A15 (4) 20 M 1/66

24. FUNERAL DIRECTOR

ADDRESS



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tone-director, page 3 should be detached for use as the burial-transit permit. Then please remove carrier papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours ofter death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

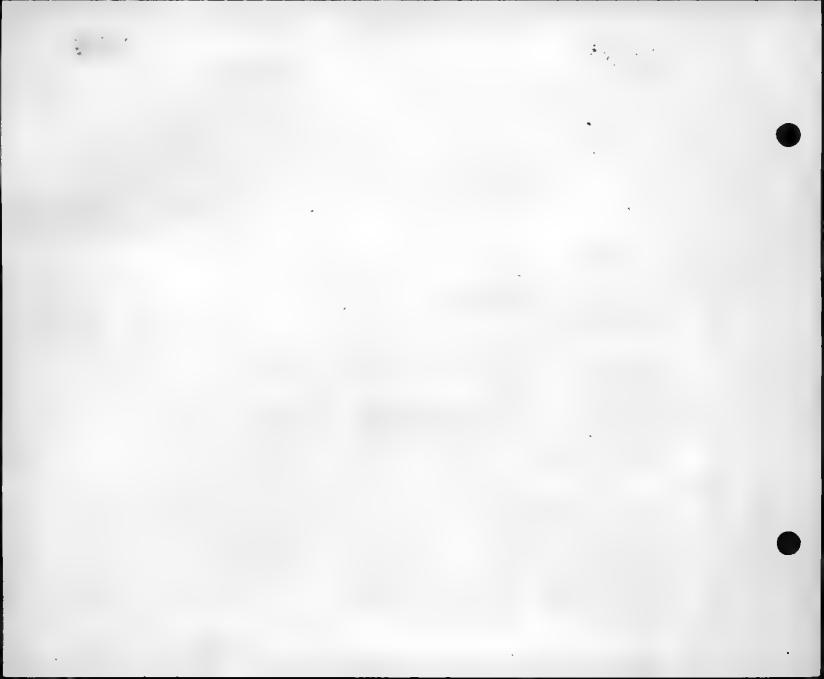
Page 4 may be retained by the hospitol or attending physicion.

VR A15 [4] 20 M 1/66

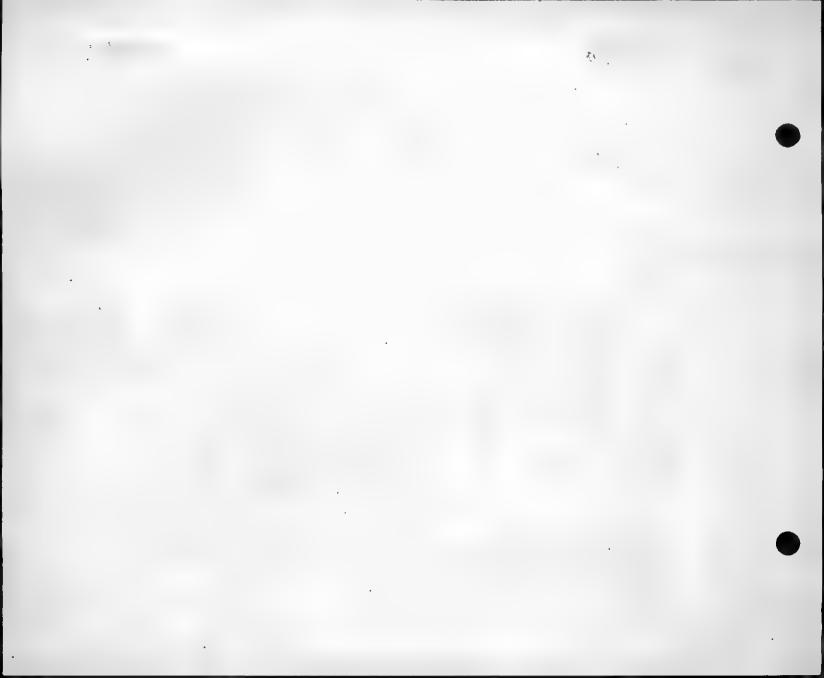
## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|                       | 04257   |  |                             | CERTIFIC                          | ATE    | OF DEATH   |                                      | 04259                         | )   |
|-----------------------|---|--|-----------------------------|-----------------------------------|--------|--|--------------------------------------|-------------------------------|---|
|                       | PLACE OF DEATH  o. COUNTY  TA   | bot  |                             | MARYLAN                           | D      | 2. USUAL RESIDENCE (Where deceosed o. STATE Maryland   | l lived, if institution<br>b. COUNTY | Residence before Dorches      | e odmission)                                    |
|                       | write RURAL and   | outside corporate limit:                             | ς, (                        | Tength of stay in it              | 12     | c. CITY OR TOWN (If outside corporate Cambridge  | fimits, write RURAL                  | ond give neores               | it town)  |
| (                     | d. NAME OF HOSPITAL   | OR INSTITUTION (If no                                | t in hospital, give s       | treet oddress)                    |        | d. STREET ADDRESS 416 Maryland A   | venue                                |                               | e IS RESIDENCE<br>ON A FARM?<br>YES NO <b>X</b> |
|                       | NAME OF<br>DECEASED<br>(Type or print)  | Ch   | rissie                      | Middle                            | 5      | Lost 4. DATE OF DEATH  | Month<br>3                           | 4 7                           | -1967   |
|                       | emale   | 6 COLOR OR RACE<br>White                             | 7 MARRIED WIDOWED           | NEVER MARRIED DIVORCED            | 3 8.   | Jan. 5, 1895   | last birthday) N<br>72 yrs.          | F UNDER 1 YEAR<br>Months Doys | IF UNDER 24 HRS.<br>Hours Min.                  |
| dun                   | ng most of work ng Irl<br>Housewi   | Give kind of work done<br>e, even if retired)<br>I e | 10b KIND O<br>INDUST<br>Hor |                                   |        | 11 BIRTHPLACE (County & Stote, or fore<br>Ringtown, Penna                                    |                                      | 12. CITIZEN OF<br>COUNTRY?    |   |
| L                     | FATHER'S NAME   | unk  |                             |                                   |        | 14. MOTHER'S MAIDEN NAME unk   |                                      |                               |   |
|                       |   | IN U.S. ARMED FORCES?<br>If yes give wor or dates o  | f service)                  | unk                               |        | Robert Snelling,   | Address<br>Cambrid                   | ge, Mary                      | land  |
|                       |   | couse (o),   | (0) Des<br>10 lu            | (b), ond (c)) celving a  e to all | ue     | clerani  | is al soul                           | 2 2 ×                         | TERVAL BETWEEN USET AND DEATH                   |
| MEDICAL CERTIFICATION | 0   | they all a   | ochestic                    | Heart des                         | an     | E TERMINAL DISEASE CONDITION GIVEN  - Ke sketes well nter noture of injury in Port I or Port | Clipes                               |                               | WAS AUTOPSY PERFORMED? TES NO                   |
| MEDICAL CE            | (IF EITHER, NOTIFY M  | (EDICAL EXAMINER)  Y Month, Doy, Yeor                | 20d. INJUR) While           | OCCURRED 206 Not While of work    |        | OF INJURY (Home, form, 20f.  | (City or town)                       | (County)                      | (Stote)   |
|                       | 21. I certify that (I) (this hospital) attended the deceased fram / / / / / / / / / / / / / / / / / / / |  |                             |                                   |        |  |                                      |                               |   |
|                       | 22c PHYSICIAN'S   | , the Har  | ui w_                       |                                   | M.D.   | L OO L ADDDICE   | STAFF PHYS.                          | 22b. DATE SIGN                |   |
| 00.                   | NAME (Type)   | THURSTO  |                             | RES DIV                           | V 00 6 | Cartre.  | liary laws                           |                               | ) (Ch.)   |
| ]                     | BURIAL, CREMATION<br>BURIAL (Specify)   | Jan 20   |                             | orchester                         |        | morial Park  | ATION (City or Town)                 |                               | , ,   |
| 124                   | I. FUNERAL DIRECTOR   | 7 7  | m ( )                       | ADDRESS                           | 下 1    | 250. REC'D BY REGISTRA MAR 2 2 196   | ant.                                 | TRAR'S SIGNATUR               | A   |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 04258 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND rebon papers. Pages I ant, w.thin 72 haurs after requires that the death certificate be executed within 24 haurs after campletely filled in by the large maken papers. Pages CITY OR TOWN (If autside carparate limits, C LENGTH OF STAY IN 15 (If outside corporate limits, write RURAL and give nearest town) write PURAL ond/give negrest town) e IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address YES NO 3. NAME OF DECEASED 4. DATE Middia Manth Day Year Last OF DEATH (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED last\_birthday) Manths Haurs Days remai and in any DIVORCED signed by the attending physician and burial-transit permit. Then please rem 12. CITIZEN OF WHAT 10a. USUA: OCCUPATION (G ve kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHREACE (County & State or foreign country) during mast of warking are, even if ret red) INDUSTRY COUNTRY? 13. FATHER'S NAME burial-transit permit. Then pl burial, crematian, ar remaval, 17. INFORMAN WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war ar dates of service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) be retained by the haspital ar attending physician. DUE TO theroselero Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been be detached far use as the State Dept. af Health priar ta last WAS AUTOPS' PERFORMED? II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO, THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES [ NO 20g ACCIDENT WAS UNDERLYING ID 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c TIME OF INJURY Manth, Day, Year Hour a.m. factory, street, office bldg, etc.) While Not While at wark at wark 21. I certify that (1) (this haspital) attended the deceased from director, page 3 shauld shauld be filed with the and that death accurred at \_M, fram causes and on the date stated abave. saw the deceased alive on 2206 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. DIRECTOR 228. PHYSICIANS I 22d ADDRESS Page 4 may 230 BURIAL CREMATION DATE THEREOF NAME OF CEMPTERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23b (County) BURIAL (Specify) 206 REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 196



| 65   |               | 04250  | CERTIFICATE                            | OF DEATH   | 6  | 14261   |
|--|---------------|--|--|--|--|---|
| the funeral<br>ages one  |               | COUNTY Talbot  | MARYLAND                               | 2. USUAL RESIDENCE (Who o. STATE                           | ere deceosed lived, if institution b. COUNTY | Residence before odmission)                               |
| by the f<br>Pages<br>aurs afte   |               | o. CITY DR TOWN (If outside corporate limits, write RHRAL and give nearest town)   | c. LENGTH OF STAY IN 16                | AFD  | de corporate limits, Frite RURA              | evilLe17  |
| filled in Papers.  | 1             | d. NAME OF HOSPITAL OR INSTITUTION (If not in hose defending the contract of t | pitol, give street oddress)            | d. STREET ADDRESS  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO                   |
| stately filled in by the carbon papers. Page within 72 haurs   |               | NAME OF DECEASED Type or print) William  | Charles                                | Leat   | 4. DATE Month OF DEATH                       | Doy Year<br>2/ 19 6/<br>IF UNDER 1 YEAR   IF UNDER 24 HR: |
| E 2 5  | S.            | MLC NEGRO WID  | OWED DIVORCED                          | MAACH 21 18  | 71 76 yrs.                                   | Months Doys Hours Min.                                    |
| by the attending physician and artransit permit. Then please remo  | dur           | USUAL OCCUPATION (Give kind of work done ng most of working life, even if retired)  FATHER'S NAME  | 10b. KIND OF BUSINESS OR<br>INOUSTRY   | 11. BIRTHPLACE (County &:  OUP N-A  14. MOTHER'S MAIDEN NA | NNA- MD.                                     | COUNTRY?  |
| ng phys<br>Then p<br>emaval,   | 15.           | CHARLES EDWA, WAS DECEASED EVER IN U.S. ARMED FORCES?  | AD TEAT  16. SOCIAL SECURITY NO. 17. 1 | EMM.   | A AND Address                                | JOEDS.  |
| attendii<br>Sermit.<br>an, ar re   | (Y            | s, no, or unknown) (If yes give wor or dotes of service  | 218-30-1009                            | ISAIAH   | H. TeAT -                                    | Centreville   |
| ran ran  |               | 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY:  151 X IMMEDIATE CAUSE (o)  DUF TO   | Can curre                              | y the S  | land   | DNSET AND DEATH   |
| signed<br>signed<br>burial-<br>burial,   |               | Conditions, if ony, which gove (b)   |  |  |  | o no,   |
| is been<br>as the<br>priar ta  |               | stating the underlying couse (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB  | UTING TO DEATH BUT NOT RELATED TO 1    | HE TERMINAL DISEASE CONO                                   | TION GIVEN IN PART 1(o)                      | 19. WAS AUTOPSY   |
| this certificate has been standed for use as the EDept. of Health prior to   | CERTIFICATION | 20o. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH   | 205. DESCRIBE HOW INJURY DCCURRED.     | Enter noture of injury in Po                               | rt 1 or Part II of item 18.)                 | PERFORMED?<br>YES NO                                      |
| CTOR: After this certification of the standard | MEDICAL CER   | (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.   |  | E OF INJURY (Home, form, ory, street, office bldg., etc.)  | 20f. (City or town)                          | (County) (Stote)  |
| After<br>After<br>J be<br>State  | W             | p.m. 19<br>21. <b>I certify</b> that (I) (this haspital)   | attended the deceased fram             | , 19<br>death accurred at                                  | -/2 to                                       | , 19, that (I) (we) lo                                    |
| DIRECTOR:<br>Be 3 shauldied with the   |               | saw the deceased alive an 3  | M.I. M.I.                              | ATTENDING 16 M   | ED. STAFF RECTOR PHYS.                       | 22b. OATE SIGNED  |
| RAL DII  |               | 22c. PHYSICIAN'S<br>NAME (Type) Arthur B. Co   |  | 22d. ADDRESS<br>Easton,                                    |  |   |
| O FUNERAL DIRECTOR PORT OF THE SHAULD BE FILED WITH THE SHAULD BE FILED | 230           | BURIAL, CREMATION, REMOVAL (Specify) 13 4 A 14 L MARCH 2-  | 23c. NAME OF CEMETERY OR               | REMATORY<br>LL P   | 23d. LOCATION (City or Town                  | (County) (Stote)  |
| VR A15 (4) 20 M 1/66   | 24            | FUNERAL DIRECTOR Confidence  | DE ADORESS  Peter VIII                 | 250. REC'D E   |  | STRAR'S SIGNATURE   |

har temperature and the 19850 - Comment the Street Contract (Contract of the Contract of the Cont , D) (A) (G. Alk and the substant of 

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Page 0 death. MARYLAND delay State Department CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. puo PM3. write RURAL and give nearest town) hours after 10 HAELS d. STREET ADDRESS. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address Idrm in pencil in Item 18. Give Poges 1, NO This certificate shauld be executed within 24 hours after death. Office along with NAME OF Middle 4. DATE Month Lost Year Doy DECEASED OF DEATH The (Type or print) with 1 YEAR IF UNDER SEX 6. COLOR OR RACE 7 MARRIED DATE OF BIRTH AGE (In years NEVER MARRIED birthdoy) Months Days Hours WIDOWED DIVORCED event CV ond USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR ag most of working life, even if retired) INDUSTRY COUNTRY LA any 8 the Chief Medical Exominer's pages .⊆ File ond 16. SOCIAL SECURITY NO **INFORMANI** WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (If yes give wor or dotes of service or removal, pending 18. CAUSE OF DEATH (Enter only one couse pe for (o), (b), burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: neumania IMMEDIATE CAUSE (o) please execute the certificate, writing the ward buriol, cremotion, DUE TO Conditions, if ony, which gove rise to immediate couse (a). forworded to DUE TO stoting the underlying couse lost. 00 used WAS AUTOPS PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) prior to pe should be 20o. EXTERNAL CAUSE WAS HOW IRJURY OCCURRED. (Enter noture of injury in Portal or Port II of item 18.) 3 should PRIMARY OF CONTRIBUTING AL EXAMINER: CAUSE OF DEATH its designated ogent, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page of work at work 21. I certify that I took charge of the remains described above, held an Autapsy ö Inspection Inquiry and in my apinian the funeral director. death resulted frame. Natural causes Suicide Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY necessary, DEPUTY MEDICAL EXAMINER Health or **EXAMINER'S** may Address (Street, city, town, or county) NAME (Type) 23c. NAME OF CEMETERY 23d. LOCATION (City or Town) BURIAL CREMATION. 23b. DATE THEREOF OR CREMATORY 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15ME (5)

6M 1/66